DOCUMENT RESUME

ED 268 401 CG 018 960

TITLE	Aging Veterans and Health Care Issues. Hearing before the Subcommittee on Retirement Income and Employment of the Select Committee on Aging. House of Representatives, Ninety-Ninth Congress, First Session (Toms River, NJ).
INSTITUTION	Congress of the U.S., Washington, D.C. House Select Committee on Aging.
REPORT NO	House-Comm-Pub-99-535
PUB DATE	24 Jun 85
NOTE	135p.; Portions of document contain small print.
PUB TYPE	Legal/Legislative/Regulatory Materials (090)
EDRS PRICE	MF01/PC06 Plus Postage.
DESCRIPTORS	*Aging (Individuals); *Delivery Systems; Health Needs; *Health Services; Hearings; *Veterans
IDENTIFIERS	Congress 99th; *Health Care Costs; New Jersey

ABSTRACT

This document contains the text of a Congressional hearing called to examine the status of aging veterans and health care issues. Opening statements are given by Congressmen Jim Saxton, Thomas J. Tauke, and Christopher H. Smith, and testimonies are presented from 20 witnesses. Members of veterans' associations testifying include representatives from a Veterans' Administration medical center, the New Jersey Veterans' Memorial Home, Disabled American Veterans, and the Veterans' Administration Clinic Task Force. Witnesses from New Jersey include the director of the Home Health Agency Assembly of New Jersey, a representative of the mayor of Hamilton Township, the deputy commissioner of the New Jersey State Department of Health, an administrator with the Garden State Rehabilitation Hospital, the public health coordinator and a public health nurse with the Ocean County Health Department, and a member of the Ocean County Board of Social Services. Other witnesses include a representative of the Health Care Financing Administration, the president of Community Memorial Hospital, a counsel for the American Association of Retired Persons, an aide to Congressman James J. Howard, a senior citizen, and two veterans. Issues examined and discussed include limits on veterans health care benefits, alternatives to institutionalization, reimbursement rates, and health care costs. (NRB)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

CG

AGING VETERANS AND HEALTH CARE ISSUES

ED268401

HEARING

BEFORE THE

SUBCOMMITTEE ON
RETIREMENT INCOME AND EMPLOYMENT

OF THE

SELECT COMMITTEE ON AGING
HOUSE OF REPRESENTATIVES

NINETY-NINTH CONGRESS

FIRST SESSION

JUNE 24, 1985, TOMS RIVER, NJ

Printed for the use of the Select Committee on Aging

Comm. Pub. No. 99-535

CG 018960

U.S. DEPARTMENT OF EDUCATION
NATIONAL INSTITUTE OF EDUCATION
EDUCATIONAL RESOURCES INFORMATION
CENTER (ERIC)

☑ This document has been reproduced as received from the person or organization originating it.

☐ Minor changes have been made to improve reproduction quality.

- Points of view or opinions stated in this document do not necessarily represent official NIE position or policy.

55-248 O

U.S. GOVERNMENT PRINTING OFFICE
WASHINGTON : 1986

SELECT COMMITTEE ON AGING

EDWARD R. ROYBAL, California, *Chairman*

CLAUDE PEPPER, Florida
MARIO BIAGGI, New York
DON BONKER, Washington
THOMAS J. DOWNEY, New York
JAMES J. FLORIO, New Jersey
HAROLD E. FORD, Tennessee
WILLIAM J. HUGHES, New Jersey
MARILYN LLOYD, Tennessee
STAN LUNDINE, New York
MARY ROSE OAKAR, Ohio
THOMAS A. LUKEN, Ohio
BEVERLY B. BYRON, Maryland
DAN MICA, Florida
HENRY A. WAXMAN, California
MIKE SYNAR, Oklahoma
BUTLER DERRICK, South Carolina
BRUCE F. VENTO, Minnesota
BARNEY FRANK, Massachusetts
TOM LANTOS, California
RON WYDEN, Oregon
GEO. W. CROCKETT, Jr., Michigan
WILLIAM HILL BONER, Tennessee
IKE SKELTON, Missouri
DENNIS M. HERTEL, Michigan
ROBERT A. BORSKI, Pennsylvania
FREDERICK C. BOUCHER, Virginia
BEN ERDREICH, Alabama
BUDDY MacKAY, Florida
HARRY M. REID, Nevada
NORMAN SISISKY, Virginia
ROBERT E. WISE, Jr., West Virginia
BILL RICHARDSON, New Mexico
HAROLD L. VOLKMER, Missouri
BART GORDON, Tennessee
THOMAS J. MANTON, New York
TOMMY F. ROBINSON, Arkansas
RICHARD H. STALLINGS, Idaho

MATTHEW J. RINALDO, New Jersey,
Ranking Minority Member
JOHN PAUL HAMMERSCHMIDT, Arkansas
RALPH REGULA, Ohio
NORMAN D. SHUMWAY, California
OLYMPIA J. SNOWE, Maine
JAMES M. JEFFORDS, Vermont
THOMAS J. TAUKE, Iowa
GEORGE C. WORTLEY, New York
JIM COURTER, New Jersey
CLAUDINE SCHNEIDER, Rhode Island
THOMAS J. RIDGE, Pennsylvania
JOHN McCAIN, Arizona
GEORGE W. GEKAS, Pennsylvania
MARK D. SILJANDER, Michigan
CHRISTOPHER H. SMITH, New Jersey
SHERWOOD L. BOEHLERT, New York
JIM SAXTON, New Jersey
HELEN DELICH BENTLEY, Maryland
JIM LIGHTFOOT, Iowa
HARRIS W. FAWELL, Illinois
JAN MEYERS, Kansas
BEN BLAZ, Guam
PATRICK L. SWINDALL, Georgia
PAUL B. HENRY, Michigan
JIM KOLBE, Arizona
BILL SCHUETTE, Michigan

JORGE J. LAMBRINOS, *Staff Director*
PAUL SCHLEGEL, *Minority Staff Director*

SUBCOMMITTEE ON RETIREMENT INCOME AND EMPLOYMENT

EDWARD R. ROYBAL, California, *Chairman*

THOMAS J. DOWNEY, New York
GEO. W. CROCKETT, Jr. Michigan
FREDERICK C. BOUCHER, Virginia
HARRY M. REID, Nevada
ROBERT E. WISE, Jr., West Virginia
HAROLD L. VOLKMER, Missouri
THOMAS J. MANTON, New York
RICHARD H. STALLINGS, Idaho
MARY ROSE OAKAR, Ohio

THOMAS J. TAUKE, Iowa,
Ranking Minority Member
NORMAN D. SHUMWAY, California
JAMES M. JEFFORDS, Vermont
MARK D. SILJANDER, Michigan
JIM SAXTON, New Jersey
HELEN DELICH BENTLEY, Maryland
HARRIS W. FAWELL, Illinois
BILL SCHUETTE, Michigan

GEO. ALLEN JOHNSTON, *Majority Staff Director*
NANCY E. HOBBS, *Minority Staff Director*

CONTENTS

MEMBERS OPENING STATEMENTS

Page

Chairman Jim Saxton 1

Thomas J. Tauke 3

Christopher H. Smith 6

CHRONOLOGICAL LIST OF WITNESSES

R. Tom Williams, medical center director, Veterans Administration Medical Center, Philadephia, PA 8

Dr. Melvin Friedman, chief executive officer, New Jersey Veterans Memorial Home, Menlo Park, NJ 14

Robert J. Mussari, assistant supervisor, Disabled American Veterans, Newark, NJ 19

Dr. Thaddeus Leoniak, member, Veterans' Administration Clinic Task Force, Brick Township, NJ 21

Steven Leone, chairman, Veterans' Administration Clinic Task Force, Brick Township, NJ 28

Hon. Bartlett S. Fleming, Associate Administrator for Management and Support Services, Health Care Financing Administration, accompanied by Tom Burke, Special Assistant to the HCFA Administrator 50

Dr. Alfred Alessi, past president, New Jersey Medical Society, Hackensack, NJ 58

John Paul Marosy, executive director, Home Health Agency Assembly of New Jersey, Inc., Princeton, NJ 62

Charles I. Kauffman, Jr., public health coordinator, Ocean County Health Department, Toms River, NJ 71

Patricia Hines, deputy director, Ocean County Board of Social Services, Toms River, NJ 75

Sister Teresa Confroy, R.N., public health nurse, Ocean County Health Department, Toms River, NJ 78

Charles F. Pierce, deputy commissioner, New Jersey State Department of Health, Trenton, NJ 88

James Schuessler, president and chief executive officer, Community Memorial Hospital, Toms River, NJ 92

Russel Heeran, national legislative counsel, American Association of Retired Persons, Berkeley Township, NJ 97

Glenn Ruskin, district representative; on behalf of Hon. James J. Howard, a Representative in Congress from the State of New Jersey 103

Tom Colitsas, on behalf of Mayor Jack Rafferty, Hamilton Township, NJ 111

Ms. Squitieri, senior citizen 114

Mr. Giubardo, veteran 116

Mary Louise Hymen, associate administrator, Garden State Rehabilitation Hospital 117

William Greenberg, veteran 119

APPENDIX

Additional material received for the record:

- Ernest B. Armstrong, Buckelew & Associates, Toms River, NJ, letter 121
- Craig A. Becker, vice president, New Jersey Hospital Association, Princeton, NJ, prepared statement 121
- Robert K. Blom, physical therapist, president, Monmouth Rehabilitation, Inc., prepared statement 122

Page

Additional material received for the record—Continued
- Mary Louise Hymen, Garden State Rehabilitation Hospital, Toms River, NJ, letter and prepared statement 124
- Paul J. Tuliano, Pemberton, NJ, letter and prepared statement 128
- Robert W. Zehntner, director, Ocean County Veterans Service Bureau, Toms River, NJ, letter 130

AGING VETERANS AND HEALTH CARE ISSUES

MONDAY, JUNE 24, 1985

House of Representatives,
Select Committee on Aging,
Subcommittee on Retirement Income and Employment,
Toms River, NJ.

The subcommittee met, pursuant to notice, at 9:20 a.m., in Holiday City, Berkeley Township, Toms River, NJ, Hon. Jim Saxton (acting chairman of the subcommittee) presiding.

Members present. Representatives Saxton, Tauke, and Smith of New Jersey.

OPENING STATEMENT OF CHAIRMAN JIM SAXTON

Mr. Saxton. I would officially call this hearing of the Subcommittee on Retirement Income and Employment of the Select Committee on Aging to order.

I am the chairman for the day, Jim Saxton. On my right is the ranking member of the subcommittee, Congressman Tom Tauke, as was mentioned, of Iowa, and, on my left, is our neighbor, Congressman Chris Smith of New Jersey. I want to welcome these two distinguished members of the committee to Berkeley Township. It is a very, very nice place to be, particularly on a nice day like this.

Field hearings provide the committee with an excellent opportunity to assess first hand the needs and concerns of senior veterans, seniors and particularly our veteran population. We will share your views with the entire Aging Committee as well as the standing committees, where we have legislative jurisdiction, on issues that have to do with health and, of course, veterans issues as well. For example, Congressman Tauke serves on the Health Subcommittee of the Committee on Energy and Commerce. He will be actively involved in the budget process and that subcommittee has jurisdiction over Medicare and Medicaid. He will be sharing the information and recommendations that emerge from today's hearing on the subject of veterans health care as well.

Congressman Chris Smith serves on the veterans subcommittee and information obtained today will be helpful to him as well.

Our first panel will address the concerns of aging veterans. There are currently 3.3 million veterans, aged 65 and older. This group constitutes 11 percent of the total veterans population. By 1990, the number of veterans in this older group is expected to increase 7.3 million or 26 percent of the veterans population. The demand for medical care from the VA is expected to increase with the number of older veterans. Congress has mandated that the VA develop current and long-term plans to address the needs for these aging veterans. The Veterans' Administration is beginning to place emphasis on alternatives to institutionalization in addition to reviewing the adequacy of the nursing home beds, and I know that, from reviewing some of the testimony that we will hear this morning, that we are going to put some emphasis on the subject of alternatives to inpatient hospital care.

We hope to learn from our veterans panel how Congress will fill the gaps in our long-term care for New Jersey veterans, in particular. I believe that additional outpatient facilities are needed, so that veterans here in Ocean County will not have to drive long distances to receive the type of health care that they need and deserve. I plan to work with Congressman Smith and other members of the veterans affairs committee to see that New Jersey receives its fair share of funding for outpatient facilities.

I might add that, at this point, Congressman Smith and I are cosponsors of the resolution, which is aimed at providing a new outpatient care facility in South Jersey, perhaps in Ocean County or one of the counties close by.

I also hope to learn how you feel about proposals to place means tests on health care and limit benefits for nonservice connected disabled. I can tell you that I am strongly opposed to the proposals in the Senate version of the budget to limit health and income benefits for veterans.

The Senate version of the budget freezes VA disability compensation and pensions for 1986. The Senate budget also imposes a means test for veterans with nonservice connected disabilities.

I believe that the veterans benefits are rights that veterans have earned for their service to their country, and they should be protected. Veterans health care benefits are also an essential part of our long-term care policies.

In view of the recent trend toward premature or early discharges from hospitals under prospective payments, the need for community-based alternatives to institutionalization has increased in order to accomodate these recovering patients. Unfortunately, they are often dumped into communities with gaps of postacute care facilities and long waiting lists, so that very unhappy and uncomfortable situations do occur.

I believe that Congress must work with the medical community, health planners, and consumers to provide resources and leadership to fill the gaps in long-term care. I have selected witnesses today who I believe can work with me and with other members of this subcommittee and with the Aging Committee in general on a long-term basis to address the issues of New Jersey. I am especially interested in your views on how Congress may remove some of the barriers to home health care and make Medicare definitions of homebound and intermittent care less restrictive for the health care beneficiaries. Finally, I am interested in knowing your views on the HCFA waiver and Medicare reimbursement for home health care as well.

On a final subject of prospective payments, I am interested in your views on the general issues of cost containment, regulation and competition in bringing medical care and inflation under control. One of our biggest enemies in general in health care, in particular.

I hope you will tell the committee what we can learn from our experience here in New Jersey with the statewide all payer system. New Jersey was a pioneer in this regard, and there is much to be learned from our system. To what extent does the cost containment jeopardize the quality of care for older patients? What is the future of our independent and community hospitals? To what extent are professional review organizations, known as PRO's, affecting access to care and the decisions to admit patients in need of acute care to hospitals?

As a member of the Energy and Commerce and Health Committee, I know Congressman Tauke will be a key player in the future cost containment and competition in the health care field.

In closing, I want to welcome all the witnesses here today and thank them very, very much for coming, especially our witness from the Health Care Financing Administration, HCFA, from Washington. We hope you will convey New Jersey's messages to Dr. Carolyn Davis, and continue to work with us in refining Federal regulatory policies that affect the quality of health care for the elderly and the veterans populations in New Jersey.

At the conclusion of each panel, we will have a limited time, a period of time for the witnesses to respond to some questions from the three of us. We will have a break after the veterans panel and reconvene shortly thereafter. If you would like to address the committee during the audience statements, that will be approximately 11:20 or 11:30, please sign the list in the back, if you are interested in being a witness this morning, or speaking to us in any regard.

Our first speaker during that time will be Mr. Tom Colitsas from Hamilton Township, who has requested to read in a statement from Mayor John Rafferty of Hamilton Township.

We will also leave the hearing record open for 30 days following today for anyone who wishes to submit statements for the record. Copies of the printed hearing will also be available from my office or from the office of the Committee on Aging.

I would like to turn now to Congressman Tauke, on my right, who I believe also has an opening statement.

STATEMENT OF REPRESENTATIVE THOMAS J. TAUKE

Mr. Tauke. Thank you very much, Mr. Chairman.

This is my first trip to the State of New Jersey. I say the first trip to the State of New Jersey, I have been to Newark before, but my colleagues to the left keep telling me you have not been to New Jersey until you have been out of Newark. And, so, I guess this is my first trip to the State of New Jersey. And, if I had known how beautiful and delightful this area is, I would have arrived earlier than 9 o'clock last night, and I would stay longer than this afternoon. I will have to come back for another visit.

The reason I came to New Jersey, however, was not to see your beautiful scenery or to visit your beaches; it was to meet the people that Jim Saxton has been telling me about for the last 6 months. Since he has come to Congress, he keeps talking about the senior citizens from Ocean County, and as I came into your retirement community this morning, I have to tell you that I was very impressed with the community that you have here, and as I reviewed the testimony last evening, I was impressed with the comments that many of you are about to make this morning.

So, it is a great pleasure to be here. Now, I do want to tell you that your Congressman has, in his relatively brief time in Congress so far, been a real champion for the elderly in Congress. He has been a very active member of the Aging Committee, and certainly has been bringing the concerns of New Jersey senior citizens to the forefront in that committee.

He took the lead in Congress in trying to preserve the Social Security cost of living adjustment and keeping that cost of living adjustment in the House version of the budget. And, he has also been trying to remove Social Security from the unified budget, so every year we do not have to go through this process of trying to determine whether or not cost of living adjustments will be granted in the Social Security Program.

I am also pleased to join my friend, Chris Smith, who also has been an activist in Congress, particularly on veterans and aging issues. He serves on the Veterans' Affairs Committee and will be touching lot of those issues this morning, and I know he will be taking your recommendations back to that committee.

Today's hearing is obviously timely because we will be looking at New Jersey's veterans concerns just as Congress is ironing out the differences in the budget, and the standing committees are deciding how to follow the changes in the budget programs under their jurisdiction.

The veterans benefits, there are differences in the two budgets, which Jim outlined in his statement. There are also differences in health care coverage. It will be helpful to hear your views on budgetary issues since we will soon be voting on a compromised budget.

The hearing is also timely as the demands of our VA health system are increasing as other health care services are decreasing. Greater cost-sharing under Medicare and Medicaid will also affect the demand for veterans services. The increased demand for veterans health services is a long-term concern.

Today, we have 3.3 million veterans aged 65 and over. That will exceed 8 million by the year 2000. Let me repeat that. Today, we have 3.3 million veterans over age 65, but we expect to have over 8 million veterans over age 65 in the year 2000.

Now, I understand that here in New Jersey you have a waiting list for beds in the VA medical centers. We do not have to speculate too far to understand that there are going to be problems as that veterans population grows.

We are interested in knowing if the solution to this problem lies in additional VA health facilities or alternatives to institutionalization. Perhaps the answer is better coordination between VA facilities and private health care providers. But, I understand that there is also a shortage of VA outpatient facilities, and I believe that outpatient facilities are a cost-effective alternative to institutionalization, if they are accessible.

Unfortunately, in rural areas, veterans often have to drive long distances to outpatient facilities. Cost containment measures for Medicare as well as other payers are receiving mixed reviews. The positive aspects of cost containment include the reduction of inflation and health care costs nationwide from 16 percent to about 5 percent, and that certainly is good news.

Private insurors are following Medicare's lead in controlling costs through more restrictive reimbursements. Traditional hospital care is being replaced with shorter lengths of stay and declining hospital admissions. Hospitals are adopting better management and accounting requirements to meet the demands of the intricate cost containment guidelines, and, in many ways, all those things are good.

However, there are negative aspects to cost containment, and we have heard stories of older patients being discharged into communities without a continuum of care, such as few visiting nurse assistants or home health care services. We are hearing that skilled nursing facilities have long waiting lists, while some hospitals have an abundance of empty beds. Hospitals in rural areas attribute their plight to Medicare's DRG rural differential and wage interface.

We hope today to learn if State waiver systems, such as New Jersey's, provide an opportunity to address the problem with reimbursement rates. While health care consumers, community hospitals and nonprofit health care providers may be the victims of our Federal cost containment system, investor owned for profit hospitals and health facilites appear to be benefitting from cost containment. For profit hospital management chains are announcing bold expansion plans. Standard & Poors reports that the Hospital Corp. of America's net earnings for September 30, 1984, rose 21 percent.

These chains obviously are able to meet the cost containment challenge by keeping their costs below DRG rates, and they benefit from shorter hospital stays because of a high turnover in patients requiring extensive procedures.

They also have access to better technology and better sources of investment capital. So, while the management chains are expanding and profitting, operating margins for community and rural hospitals are declining.

We are especially interested in learning your views on reforms which would foster the expansion in home health and other community-based supportive services. I am interested in knowing if there are adequate planning and coordination among the providers of medical services in community-based support services.

For instance, when hospitals discharge elderly patients who are a long way from recovery, are community services and referrals part of the patient's overall case management? The medical profession certainly has a role to play in the quality of care issues, accessibility to health services and cost containment. Hospitals have a role to play also, and rural and community hospitals are responding to the problems of empty beds as a result of cost containment by transferring resources into alternative modes of health care, such as ambulatory care, nursing and long-term care, swing beds and home health care.

The final chapter in our discussion of long-term care is the financing of these programs. I am pleased that the evidence suggests that private insurors are following Medicare's lead in holding down costs and bringing down inflation in health care.

However, I believe we will eventually have to address the issue of catastrophic health care coverage to finance the long-term services that will be demanded by tomorrow's elderly population.

The solution to all of our problems rests in the pooling of resources and ideas among Federal, State and health care communities.

Mr. Saxton, your congressman, is to be commended for bringing together those elements for today's hearing, and I thank you, Jim, for inviting me.

STATEMENT OF REPRESENTATIVE CHRISTOPHER H. SMITH

Mr. SMITH. Thank you. My name is Chris Smith. I represent the fourth district, which is just north of here, and, first of all, I would like to thank my good friend and colleague, Jim Saxton, chairing today's meeting, for hosting this hearing of the Select Committee on Aging, on the very important topic of health care for the aging veterans, health care under the prospective payment system, and home health care as an alternative to institutionalization.

I also want to welcome my good friend and colleague, Tom Tauke, from Iowa, and Tom was mentioning what a beautiful day it is. It is unfortunate you did not bring your trunks, so you can sample some of the New Jersey shores.

Mr. TAUKE. I was wondering if we could check out the swimming pool during the break.

Mr. SMITH. During the break, we will.

The hearing will convene out on the terrace.

But, I am very happy to be here to join all of you, and I look forward to the various witnesses who will appear before us today.

First of all, Mr. Chairman, at present approximately 11 percent of the U.S. population or 24 million people are aged 65 or over. While the total population is expected to increase by 40 percent between 1980 and the year 2030, the elderly population is expected to more than double to a total of 55 million people.

I would point out to the members of this committee that according to the VA, the number of veterans over 65 will double by 1990, thus putting a greater burden on the VA health care delivery system.

Of great concern to the health care community and to me, as a member of the subcommittee on hospitals and health care of the veterans affairs committee, is, in fact, that the number of veterans who are over 75 years of age—those in the greatest need of medical care—will quadruple by the turn of the century.

In order to handle the tremendous influx of elderly into the health care system, whether it be Federal, State or private, we will need a comprehensive plan to assure that our seniors will receive quality health care, thus assuring, to the extent possible, that their latter years will be healthy and productive.

One step of several which I have taken in that regard is to introduce a bill, H.R. 1424, which would establish a VA satellite out-patient clinic in southern New Jersey. This bill has been cosponsored by every member of the New Jersey congressional delegation, and represents a bipartisan acknowledgement of the increasing need and continuing effort by the Congress to improve access to quality health care here in south Jersey.

The need for such facilities can be demonstrated, Mr. Chairman. The 1984 medical district initiated program planning, the MEDIPP study for the VA in region 2 pointed out that Ocean County has the greatest need for an out- patient clinic with bordering Atlantic County coming in third.

I would point out to my colleagues that the study found that there would be approximately 51,000 service-connected businesses per year in Ocean County alone, which is three times the amount needed for construction of such a facility.

Mr. Chairman, not only must we assure the availability of health care, we must also insist that health care be provided at a reasonable cost since the elderly, most of whom live on modest fixed incomes, are least able to absorb the financial burdens brought about by increases in health inflation.

Indeed, Congress has begun to work towards containment in various ways, including freezes on physician fees as well as the DRG system. It is our job, however, to continue to look ahead for long-range solutions, such as increased use of home health care.

Mr. Chairman, I look forward to the testimony that will be provided, and this hearing will certainly be of benefit to our colleagues on the aging committee.

I yield back the balance of my time.

Mr. SAXTON. Thank you very much, both Congressman Tauke and Congressman Smith, and may I ask the first panel to come up and while they are on their way up, let me just say that I guess it was about 8 months ago that I first traveled to Washington, D.C., as a newly elected Member of Congress. I had no idea how busy the life of a Congressman is. I say that because these two gentlemen on my right and on my left both traveled a long distance to get here today and they could have been home with their families or playing golf or whatever you do on a day off because today is an unofficial day off, if you will, for Congress.

But, they are both here with me today, and I appreciate that very, very much. They certainly should be commended for that, and we can all thank them for coming to listen to our testimony.

I might say that we do have some time constraints. I know that you all have prepared text, and certainly the prepared text will be made part of the official record. We would appreciate whatever you could do to make your statements this morning as concise as possible and, of course, direct and to the point.

Thank you very much for coming. Let me introduce Mr. Bob Williams, director of the VA Medical Center in Philadelphia; Melvin Friedman, chief executive officer, New Jersey Veterans Memorial Home; Bob Mussari, a personal friend of mine, assistant supervisor of the Disabled American Veterans; Dr. Thaddeus Leoniak, a member of the Veterans Administration Clinic Task Force; and Steve Leone, chairman of the Veterans Administration Clinic Task Force in Ocean County.

You might guess that this is a panel on our aging veterans population. So, if we may start with Mr. Williams, director of the VA Medical Center.

STATEMENT OF R. TOM WILLIAMS, MEDICAL CENTER DIRECTOR, VETERANS ADMINISTRATION MEDICAL CENTER, PHILADELPHIA, PA

Mr. **Williams**. Thank you, Mr. Chairman.

Mr. Chairman and members of the committee, I am pleased to have the opportunity to discuss the challenge of providing health care to the aging veteran population.

The Veterans Administration is facing a major challenge, a very rapidly aging veterans population. Although the whole American population is growing older, the growth in the number of aging is even more rapid in the veterans group. As you have heard the Congressmen mention, by 1990, veterans over 65 will make up more than one quarter of the veterans population, and, by the year 2000, will be almost one-third of the entire veterans population. Here, in the State of New Jersey, of the approximately 900,000 veterans, about 17 percent are currently 65 years and older. In view of the health problems that accompany the aging, the VA can expect both increased demand and different kinds of demand for services. These changes have already begun to appear in the patients using our VA hospitals and out-patient facilities. They are also increasingly becoming recognized by the larger population. For example, the recent congressional budget office study on Veterans Administration health care and planning for the future years, which was published last year.

In order to learn more about the aging veterans and their general health, socioeconomic status, and their daily living conditions, the VA commissioned Louis Harris & Associates to conduct a nationwide survey of 3,000 veterans, aged 55 and over. This special study complements the VA's ongoing internal planning efforts to determine the changing veterans' needs. An accurate assessment of veterans health care needs and the projection of their impact on the geriatric concerns in the future have been a high priority item in the VA Department of Medicine and Surgery, as well as our Department of Veterans Benefits and Memorial Affairs.

The VA has responded to this challenge through the development of comprehensive reports, which represent the necessary data, analysis and options for which the necessary veterans discussion can occur. This report, which I am sure the Congressmen have seen and many of you have, is called "Caring for the Older Veteran." It is based on a set of assumptions, which not only can but must be carefully debated to ensure that all options are considered to meet the needs of the veterans at an affordable cost. Other reports on the challenge, such as the CBO study and the options they offer will form a welcome addition to this discussion.

In developing this VA report, a fundamental issue was to project the real needs for future care, for which the VA might be responsible. Since there was no reliable information on future changes in Medicare or Medicaid, the projections were based on the assumptions that Medicare and Medicaid would continue to meet about the same needs as they previously are being met. This means that taking all veterans 55 and over in the country, some 37 percent of them, have Medicare coverage, and for those 65 and over, about 90 percent of those veterans were covered by Medicare. That is both parts A and B in most cases.

The need is difficult to quantify precisely. The VA worked on the report for over 1 year and developed three real need methodologies for projecting the needs after the year 2020. These were compared with the two demographic only projections, one by the Congressional Budget Office and one by the VA MEDIPP data. The range of projected needs for VA hospitals, ambulatory care, and institutional long-term care are all above the current levels of operation and should keep in the period 2000 to 2010.

National data shows that the American men, 65 and over have more than twice the number of hospital days per capita than do men in the age group from 45 to 54. Veterans use of VA hospitals and outpatient clinics has a similar pattern. Those 65 years and older represent 31 percent of the VA hospital discharges and 20 percent of our total outpatient workload.

The Veterans' Administration has been aware for some time of the special opportunity and the awesome responsibility that we have as a result of the aging clientele population we serve. The increase in the number of veterans and others reaching old age represents a tremendous success story. Improvements in public health, reductions in childhood mortality and disease, new discoveries about diseases and their treatment, and changes in personal lifestyles all have contributed to making this story a success. The solutions which have supported the aging population, however, has created a situation which is universally now being viewed as a problem, and, that is, how do we meet the needs of this changing population?

Most elderly people and veterans live in their own households within the community. The primary goals for the elderly, therefore, should be to try to maintain their physical and psychological well-being, their financial security, and their intergration with society, which is critical to their functional dependence.

Not all of the aged are sick an functionally dependent as most people think. In fact, the data indicate that a significant portion of the elderly lead relatively healthy and unimpaired lives. With old age, however, comes the greater likelihood of illness, functional impairment, and increased dependency.

Family and friends provide an estimated 60 to 80 percent of the supportive care needed by senior citizens. For those without financial resources and this informal support, infirmities can translate into a much greater need for support, for formal service providers, often in the form of hospital or some other institution.

Developing the balance between fostering independence and providing the necessary needs and programs is the challenge of the VA. The VA Medical Center is addressing these increased medical care requirements of the aging population by providing high quality, comprehensive, acute, and long-term care, by developing and maintaining pertinent educational programs, and by carrying out a health services research program that tries to improve the status and well-being of the elderly.

Models of care have been developed, along with the traditional acute care services, that respond specifically to the needs of the older veteran. The intent is to provide elderly veterans with a range of medical and health services that are designed to restore and maintain optimal health, to foster their independent living, and to improve their quality of life.

We have set up a number of geriatric evaluation units, which will, hopefully, help us to better serve the needs of the elderly veterans as they are placed outside of hospitals. We currently have 43 such geriatric evaluation units, including one of them at our hospital in Philadelphia.

We have an extended care program, which provides a broad spectrum of both institutional and noninstitutional care in the VA. Since this report came out last year, "Caring for the Older Veteran," we have made considerable progress in trying to meet the needs of older veterans.

I will summarize quickly, just some of the highlights of the program that we are currently planning and currently that are in action here in 1985, that will increase—meet the needs of the older veterans.

Many of the VA facilities are developing special programs related to medical, psychiatric, and rehabilitative needs for the frail elderly, the ones who do not have this informal support. We have advanced diagnostic techniques, which are being incorporated into medicine, which will help us, hopefully, improve the assessment and care planning for the elderly patient, with chronic and acute care problems.

To meet the long-range, long-term care patients, particularly those in nursing homes, we have several extended care programs that we are expanding during this year of 1985. For example, we have five new geriatric evaluation units that are being implemented for a total of 45. We have 6 new hospital-based home care programs that we are initiating, which will give us a total of 49. We have five additional adult day care centers which will be in operation by the end of the year, for a total of nine. We have 11 new VA nursing home care units that are being added, and that brings us to a total of a 116. We have two more geriatric research, education and clinical centers. That gives us a total of 10 of those.

We have a number of State home construction and renovation projects, which will be continuing and will be completed this year, and, hopefully, some new ones initiated.

During 1985, we had 54 medical centers providing support to a 103 geriatric trainees in the field of social work, psychology, optometry, audiology, and speech pathology. We have 24 physicians and 5 dentists, supported by geriatric fellowships, to complete their training, and 45 master degrees students in geriatric and gerontology nursing.

We have 18 funded research projects related to the biological process underlying aging. We have some studies in the area of Alzheimer's disease. We have a new multisite research project involving 10 medical centers on studying the prevalence of eye disorders among the older veterans, and we are developing an evaluation of our adult day care programs to see about its benefits and its cost effectiveness.

These are what we as our needs for the future in planning for taking better care of the older veterans, and we hope to meet this challenge, and I appreciate the oppportunity of being here this morning to discuss it with you.

And, Congressmen, the complete text of my transcript is available for you all.

[The prepared statement of Mr. Williams follows:]

PREPARED STATEMENT OF R. TOM WILLIAMS, MEDICAL CENTER DIRECTOR, VETERANS' ADMINISTRATION MEDICAL CENTER, PHILADELPHIA, PA

Mr. Chairmen and Members of the Committee: I am pleased to have the opportunity to discuss the challenge of providing health care to the aging veteran population.

The Veterans Administration is facing a major challenge—a very rapidly aging veteran population. Although the whole American population is growing older on the average, the growth in the number of aged is much more rapid in the veteran group. By 1990, veterans over 65 will make up more than a quarter of the veteran population and, by 2000, will reach slightly over one-third. In the State of New Jersey, of the approximately 900,000 veterans, about 17 percent are currently 65 years or older. In view of the health problems which accompany aging, the Agency can expect boty increased demand and different kinds of demands for services. These changes have already begun to appear in the patients using VA's hospitals and outpatient facilities. They are also increasingly being recognized by the larger community; for example, in the Congressional Budget Office (CBO) Study "Veterans Administration Health Care: Planning for Future Years," published last year.

In order to learn more about the aging veterans and their general health, socioeconomic status, and daily living conditions, the VA commissioned Louis Harris and Associates to conduct a nationwide survey of 3,000 veterans aged 55 and over. This special study complements VA's ongoing internal planning efforts to determine changing veteran needs. Accurate assessment of veterans' health care needs, and projection of their impact on geriatric concerns in the future have been a high priority item in the Medical District Initiated Program Planning (MEDIPP) activity of the Department of Medicine and Surgery (DM&S) in each of the past three years. Similarly, the Department of Veterans Benefits (DVB) and the Department of Memorial Affairs (DMA) have focused their planning efforts on assessing the effects of an aging veteran population on their elements of the Agency's mission.

The VA has responded to this challenge through the development of a comprehensive report which presents the necessary data, analysis and options from which a necessary policy discussion can occur. This report—CARING FOR THE OLDER VETERAN—is based upon a set of assumptions which not only can but must be carefully debated to ensure that all options are considered to meet the needs of veterans at an affordable cost. Other reports on the challenge, such as the CBO study, and the options they offer will form a welcome addition to the discussion.

In developing the VA report a fundamental issue was to project the real need for future care for which the VA might be responsible. Since there was no reliable information on future changes in Medicare and Medicaid, the projection was made based on the assumption that Medicare and Medicaid would continue to meet the same needs as previously met. This meant that taking all veterans 55 and over in the country, some 37% of them had Medicare coverage and for those 65 and over, about 90% of those veterans were covered by Medicare—both Parts A and B in most cases.

The need is difficult to quantify precisely. VA worked on the report for over a year and developed three "real need" methodologies for projecting need out to the year 2020. These were compared with two demographic only projections, one by the Congressional Budget Office and one from VA's MEDIPP data. The range of projected need for VA hospital, ambulatory and institutional long-term care are all above the current levels of operation and peak during the period 2000-2010.

National health data show that American men 65 and over have more than twice the number of hospital stays per capita than do men in the 45-64 age group. Veterans' use of VA hospitals and outpatient clinics has a similar pattern. Those 65 years and older represent 31% of VA hospital discharges, and 28% of VA outpatient visits.

The Veterans Administration has been aware for some time of the special opportunity and awesome responsibility it has as a result of the aging of its client population.

The increase in the number of veterans and others reaching old age represents a tremendous success story. Improvements in public health, reductions in childhood mortality and disease, new discoveries about diseases and their treatment, and changes in personal lifestyles all have contributed to making the story a success. The "solutions" which have supported the aging of the population have created a situation, however, that is almost universally viewed as a "problem"—how to meet the needs of this changing population.

Most elderly people and veterans live in their own households within the community. The primary goals for the elderly should be to maintain their physical and psychological well-being, their financial security, and their integration with society, which is crtical to their functional independence.

Nevertheless, aging is widely associated with the gradual decline in the individual's ability to function independently. Longer life is similarly associated with a higher occurrence of disease. Death may shorten the period of decreasing capacity, but for many people there is an inevitable onset of increasing frailty.

Much of this frailty can be compensated for if the proper medical and support services are available to the older individual. Such services must, however, be both timely and coordinated if they are to be effective in maintaining the maximum feasible degree of independence.

In providing health care to the elderly, promotion of the maximum level of functional independence is the fundamental goal.

It is commonly beleived that "old age" (i.e., 65 plus) is synonymous with illness, disease, and functional incapacity. This supposition may be true to the degree that humans do experience a decline in numerous physiological functions as they age, but these declines are normally gradual—often extending over decades.

In general, old age, in the absence of disease, is a period of relatively good health and sustained ability to function. While "aging" as a biological process is inevitable, it continuous and progressive nature relate to an indivdiual decline in adaptability.

To make a correlation between physiological age and chronological age is difficult. It is equally difficult to determine when physiological changes become pathological. Much is now known about the "aging" of the nervous system, endocrine function, ability to fight infection, and cardiovascular performance. Yet the distinction between these "aging" changes and pathology is rarely clear.

While there is, with increasing age, a gradual loss of vigor, most of the maintenance of independence relates closely to the severity of physical, mental, and social disabilities in the elderly.

Due to multiple diesease conditions and increasing frailty, the aged often exhibit a diminished capacity to function effectively and independently. One general indicator of decreased well-being is the heightened prevalance of activity-limiting conditions.

It has been documented that the proportion of a given population with some activity limitation increases significantly with age.

Indicators of health status reflect the greater health needs and the decreasing capacity for independence of an aged population. Disease and chronic disability impair capacity to carry out the usual activities associated with daily living, and this impairment creates the need for sustaining services.

Eventually, the availability of helpers who function as the primary network to support activities of daily living is crucial if the elderly are to maintain independence while experiencing decline in function. The availability of family or friends and the financial means to pay for services greatly affect the ability to function independently.

Not all of the aged are sick and functionally dependent. In fact, the data indicate that a significant portion of the elderly lead relatively healthy and unimpaired lives. With old age, however, comes the greater likelihood of illness, functional impairment, and increased dependency.

Family and friends provide an estimated 60 to 80 percent of the supportive care needed by senior citizens. For those without financial resources and informal support, infirmities can translate into a much greater need for support from formal services providers, often in the form of institutional care.

Although much about the future health needs of the elderly remains unresolved, there is no lack of clarity regarding the correlation between age and greater health care needs and the higher consequent use of resources.

Providing sustaining care for the elderly will have to continue to be compassionate, efficient, and effective. If the cost is not going to become prohibitive, then mechanisms that ensure continuity will have to be directed towards the truly needy.

Developing a balance between fostering independence and providing the necessary services and programs in the event of deterioration is vital.

The BA medical care system is addressing the increasing medical care requirements of the aging veteran population by providing high quality, comprehensive, acute and long-term care; by developing and maintaining pertinent educational programs, and by carrying out a health services research program that strives to improve the status and well being of the elderly.

Models of care have been developed, along with the traditional acute care services, that respond specifically to the health needs of older veterans. The intent is to provide elderly veterans with a range of medical and health services that are designed to restore and/or maintain optimal health, foster independent living and improve the quality of life.

Geriatric Evaluation Units are developed in medical centers to improve diagnostic assessment, treatment, and placement of older patients who may have some remediable impairments, multiple chronic diseases, or psycho-social problems which need to be fully assessed. GEU's also provide training and research opportunities for physicians and other health care professionals. There are 43 GEU's presently operating in the VA hospital system and one is located at the Philadelphia VA Medical Center.

The VA's Extended Care programs encompass a broad spectrum of institutional and non-institutional care. The range of progrms, in addition to extended hospital care (intermediate care) and outpatient care, includes: nursing home care, which has three components—the VA's own nursing home care programs, the community (contract) nusing home care program, and the state nursing home care program; the domiciliary programs of both the VA and the states; the hospital based home care program; the adult day health care program; the community residential care program; and one prototype hospice program caring exclusively for the terminally ill.

Since the report, "Caring for the Older Veteran," was published in July 1984, considerable progress has been made toward meeting the increasing care needs of older veterans. I will summarize some highlights of the program plans and actions that are being taken this year (1985) to meet the increasing care needs of older veterans.

Many VA facilities are developing special programs related to medical, psychiatric and rehabilitative care needs of the "frail" elderly.

Advanced diagnostic techniques are being incorporated into medicine which will improve the assessment and care planning for elderly patients with acute and chronic health programs.

To meet the projected increases in long term care patients, particularly those requiring nursing home care, several extended care programs are being expanded this year (FY 1985) and the totals are indicated:

Five more Geriatric Evaluation Units (GEUs) will be implemented and 34 staff members added to the programs of 17 GEUs. Total 45.

Six Hospital Based Home Care (HBHC) programs will be initiated. Total 49.

Five additional Adult Day Health Centers (ADHC) will be in operation by the end of 1985. Total 9.

Eleven new VA Nursing Home Care units are being added. Total 116.

Two more Geriatric Research, Education and Clinical Centers (GRECCs) will reach full activation. Total 10.

A number of State Home Care construction and renovation projects will be continuing as well as new ones initiated.

A national training conference was held in May, 1985, to focus on methods and strategies for expanding VA and community joint efforts in the development, coordination and integration of services for elderly, "at-risk" veterans.

The VA's gerontology research and training programs will continue to prepare physicians and other health workers to deal with the problems of aging.

During 1985, 54 medical centers will be providing support to 103 associated health geriatric trainees in such fields as social work, psychology, optometry and audiology and speech pathology.

Twenty-four physicians and five dentists, supported by Geriatric Fellowships, will complete their training; and 45 masters degree students in Geriatric/Gerontology Nursing will be using VA facilities as part of their studies.

Biomedical research related to aging will be conducted in the Geriatric Research, Education and Clinical Centers. One medical center is being designated as an Alzheimer's Disease Research Center. Other research activities will include:

18 funded research projects related to the biological processes underlying aging.

A cooperative study to test the effectiveness of physostigmine in Alzheimer's Disease.

A multi-site research project (10 VAMCs) to study the prevalence of eye disorder among older veterans, and

Development of an evaluation of the Adult Day Health Care program regarding its benefit and cost effectiveness.

Although considerable progress has been made in the past few years toward meeting the increasing care needs of older veterans, the challenge is still ahead. Older veterans represent the majority of patients being cared for in VA, community and State nursing homes. The average daily census and number of patients treated during the last year increased for all types of nursing home care programs. The increase in census for nursing home care and community residential care are expected to continue in the future along with an increase in patients treated in the Hospital Based Home Care Program. Many of these older veterans will need acute care and outpatient services in the future as well as extended care. VA's report, "Caring for the Older Veteran" addresses the future health care needs of the growing number of aging veterans and presents some strategic options and objectives. The assessment of future resource requirements is a dynamic variable of changing technology, health characteristics, economic conditions, availability of private sector health care, changes in VA eligibility, and other economic factors.

REFERENCES

Sources for text of testimony: Demographics-"Caring for the Older Veteran", Preface, para. 1-3; HVAC hearing, April 23, 1985, testimony of John W. Ditzler, M.D., pg. 4.

Special Needs and Current Year Plans & Actions—Actions Taken to Serve the Older Veteran, A Progress Report, Attachment A to (00) letter to Congressman Montgomery, February 7, 1985.

Previous testimony: House Select Committee on Aging, August 27, 1984, Boundbrook, NJ: Dr. John Mather, ACMD for Geriatrics and Extended Care; Mr. Peter Baglio, Director, East Orange, VAMC; and Mr. Paul Kidd, Director, Lyons, VAMC.

Other references: Estimated Vet. Pop. by State and Age, March 31, 1984; New Jersey Vet. Pop. by County, March, 31, 1984.

Mr. SAXTON. Thank you very much, and you will be sure that we get a complete copy of your testimony so that we can make it a part of the official record. We would appreciate it.

Mr. Friedman. Dr. Friedman, I should say.

STATEMENT OF DR. MELVIN FRIEDMAN, CHIEF EXECUTIVE OFFICER, NEW JERSEY VETERANS MEMORIAL HOME, MENLO PARK, NJ

Dr. FRIEDMAN. Mr. Chairman, members of the committee, my name is Dr. Mel Friedman, and I am presently the chief executive officer of the New Jersey Veterans Memorial Home at Menlo Park, one of two State homes in New Jersey.

The literature today is replete with demographic statistics, that places the present veterans population over the age of 65 at 3 million, with the anticipated increase of 2 to 3 times that number or approximately 9 million by the year 2000.

Similarly, the number of veterans 75 years old and older will increase to in excess of 4 million by the year 2000.

What do these demographic characteristics of these 3 million veterans over 65 years of age reveal? First of all, only 3 percent of them are female. The vast majority of aging veterans live with spouses or other family members at home, rather than alone, and a majority of veterans, over the age of 65, describe their health as excellent or good compared with others their own age. This group reports psychological and psychomatic problems, which are not dissimilar, to those reported by the general population. Although this group reports that their activities are limited in some way by health, they do not appear to produce functional impairment which requires support services.

What becomes readily apparent is that although the veterans population, aged 65 and over, statistically appear to be in reasonably sound physical condition, the very explosion within their numbers over the next 15 years will require our immediate attention in order to only maintain the same level of service presently provided—being provided to this group. Although purchase of care and home health care services are available to that portion of the veterans population which requires these services, the preponderance of these individuals requiring a long-term care facility must either rely on the Veterans' Administration or one of the 42 State veteran nursing homes, located throughout these United States.

But, these long-term care veterans facilities, whether VA or State operated, are too few and have lengthy waiting lists. New Jersey, with its 138,000 veterans, over the age of 65, has insufficient beds to provide services to those individuals in need. Both Lyons VA Medical Center and East Orange VA Medical Center have waiting lists in excess of 6 months. Menlo Park and Vineland Veterans Memorial Homes have waiting lists close to or in excess of 1 year. Although Lyons Hospital has been approved for a 240-bed nursing facility, East Orange Hospital has plans for expanding their 60-bed nursing unit by 30 beds, and the Division of Veterans Programs and Special Services will be opening a third State center and home in Bergen Pines later this year, all demographic statistics point up to the startling fact that the demand will far exceed the supply of beds.

Not only will there be 3 times the veterans population over 65 by the year 2000, but one must also factor into this equation that medical breakthroughs have increased the life expectancy of our aged population. What we must then face is the reality that not only are waiting lists projected to increase considerably over the next 15 years, but that the period of time a member remains in a nursing home will also increase because of continuing medical advances.

Home health care permits an individual to reside in the community until such time as closer supervision is necessary and concurrently makes a long-term bed available to some less fortunate veteran. Although this option presently exists for the aged veteran today, the cost to the individual or his family is oftentimes prohibitive. At $100 dollars per day, how long would it take the average family to exhaust its life savings? Perhaps we can consider some form of Federal tax relief for the aged veteran should he wish to remain in a community environment rather than selecting the option of entering a VA or State nursing home facility should a bed be available.

Second, once the aged veteran reaches that level of physical deterioration which requires his placement in a nursing facility, every effort should be made to permit him to retain his ties with the community. This can only be accomplished if the veteran is afforded the opportunity of extended home visitations of a duration in excess of what the VA presently allows. With the existing legislation, should a veteran be on furlough from a long-term care facility in excess of 96 hours, no portion of that leave may be claimed by the nursing home for purposes of VA reimbursement.

The current per diem reimbursement rate for State veterans nursing home care and domiciliary care are $17.05 per day for nursing, and $7.30 for domiciliary. Should an excessive number of community visitations in excess of 96 hours be approved in the course of a year, the nursing home administrator is sure to be brought to task by his governing board. Perhaps one might wish to consider permitting each veteran in a nursing home the opportunity of taking a 1- or 2-week period of time apart from the nursing home without asking the for-profit proprietary homes to subsidize this vacation.

Although our nursing homes provide outstanding services to the community, the 96-hour rule impedes them from permitting the aged veteran from spending a reasonable period of time with his spouse, son, daughter, or other loved ones.

To reconcile these issues, I offer the following for your consideration:

Provide Federal tax relief to those veterans or his family who are willing to care for their veterans who would otherwise be placed in a nursing facility. Proprietary nursing homes presently receive reimbursement of $60 per day to provide nursing home care. In addition, the 1984 nationwide per diem rate to maintain a nursing home patient in a VA environment was $106 per day. By allocating a portion of that amount to the family of an aged veteran in the form of a tax rebate, it would improve the quality of life of the individual and would prove to be far more cost efficient. At the same time, it would subsidize the family, which could then afford to purchase the services of a home health care nurse or aide during normal working hours, when both the husband and the wife, with an aging veteran parent, might be required to work.

Second, once the veteran's physical condition warrants placement in a nursing home, this should not result in his losing family identity. The patient should be permitted to take extended visitation. An increase in the 96-hour rule would afford the veteran an opportunity to remain in his family environment for a more reasonable period of time.

Last, some thought should be given to discouraging the VA from building additional VA nursing facilities and, rather, divert these funds to the States so as to provide the incentive necessary to ensure that each of the 50 States participates in a State veteran nursing home program. With proprietary per diem costs approaching $60 plus per day, and VA per diem rates in excess of $106 per day, it is certainly far more cost efficient to encourage State expansion of the nursing home programs at the present $17.05 per diem reimbursement rate.

Further, title 38, as amended, authorizes the VA to participate in up to 65 percent of the cost of new housing, nursing home construction. By increasing both the funds available to the VA for this purpose and permitting them to assume a greater percentage of the construction costs of new facilities, it would permit the States and the VA to provide services to a greater number of aged veterans more efficiently and, at the same time, would provide some relief to those increased numbers of veterans who will be vying for the limited number of nursing care beds required between now and the year 2000.

What is clear is that some serious consideration should be given to these issues before the World War II veterans begin to seriously impact on the nursing home waiting lists.

Congressmen, I would like to thank the members of the committee for the opportunity of addressing this distinguished body, and I would hope that my contribution today would, in some small part, assist you in successfully meeting the challenges of tomorrow.

My full text is also available.

[The prepared statement of Dr. Friedman follows:]

Prepared Statement of Dr. Melvin Friedman, Chief Executive Officer, New Jersey Veterans Memorial Home, Menlo Park, NJ

Mr. Chairman and members of the committee. My name is Dr. Melvin Friedman, and I am presently the Chief Executive Officer of the New Jersey Veterans Memorial Home at Menlo Park, one of two State Veterans Homes in New Jersey. I would like to thank you for the privilege of appearing before this distinguished committee to discuss some pressing issues pertaining to the aging veteran population.

The literature today is replete with demographic statistics which places the present veteran population over the age of sixty-five at 3,000,000 with an anticipated increase of three times that number or 9,000,000 by the year 2000. Similarly, the number of veterans 75 years old and older will increase to in excess of 4,000,000 by the year 2000.

What do the demographic characteristics of these 3,000,000 veterans over 65 years of age reveal? First of all, only 3% of them are female. The vast majority of aging veterans live with spouses or other family members at home rather than alone and the majority of veterans over the age of 55 describe their health as excellent or good compared with others their own age. This group reports psychological or psychosomatic problems at rates which are not dissimilar to those reported by the general population. Although this group reports that their activities are limited in some way by their health, they do not appear to produce functional impairments which require support services.

A recent study conducted by the VA reveals that most veterans are in reasonably sound financial condition with the average household income in 1982 being $20,900.

What becomes readily apparent to this author is that although the veteran population age 65 and over appear to be in reasonably sound physical condition, the very explosion within their numbers over the next fifteen years will require our immediate attention in order to only maintain the same level of service presently being provided to this group. Although purchase of care and home health care services are available to that portion of the veterans population which require these services, the preponderance of these veterans requiring a long term care facility must either rely on the Veterans Administration or one of the forty-two State Veterans Nursing Homes located throughout these United States.

But these long term care veteran facilities, whether VA or State operated, are too few and have lengthy waiting lists. New Jersey, with its 138,000 veterans over the age of 65 has insufficient beds to provide services to those individuals in need. Both Lyons VA Medical Center and East Orange VA Medical Center have waiting lists of six months or more. Menlo Park and Vineland Veterans Homes have waiting lists close to or in excess of one year. Although Lyons Hospital has been approved for a 240 bed nursing facility, East Orange hospital bus plans for ex panding their 60 bed nursing unit by 30 beds, and the Division of Veterans Programs and Special Services (Department of Human Services) will be opening a third State Veterans Home in Bergen Pines later this year, all demographic statistics point up to the startling fact that the demand will far exceed the available supply.

Not only will there be three times the veterans population over 65 by the year 2000, but one must also factor into this equation, that medical breakthroughs have increased the life expectancy of our aged veteran population. What we must then face is the reality that not only are waiting lists projected to increase considerably over the next fifteen years, but that the period of time a member remains in a nursing home will also increase because of continuing medical advances.

Is the answer to this population explosion simply to continue to build additional nursing homes? I think not. Rather, one should look to altelrnative means by which to provide services to these veterans which might serve to complement the nursing home program. At a minimum, one should consider some means by which the aged veteran might remain in the community until his physical condition deteriorates to that point whereby a long term care environment must be considered.

Home health care permits an individual to reside in the community until such time as closer supervision is necessary and concurrently makes a long term bed available to some less fortunate veteran. Although this option presently exists for the aged veteran today, the cost to the individual or his family is oftentimes prohibitive. At $100.00 per day, how long would it take the average family to exhaust its life's savings? Perhaps we can consider some form of Federal tax relief for the aged veteran should he wish to remain in a community environment rather than selecting the option of entering a VA of State nursing facility, should a bed be available.

Secondly, once the aged veteran reaches that level of physical deterioration which requires his placement in a nursing facility, every effort should be made to permit him to retain his ties with the community. This can only be accomplished if the veteran is afforded the opportunity of extended home visitations of a duration in excess of what the VA presently allows. With the existing legislation, should a veteran be on furlough from a long term care facility in excess of 96 hours, no portion of that leave may be claimed by the nursing home for purposes of VA reimbursement. Should a patient wish to take an extended leave from the facility in excess of 96 hours, the State and proprietary homes must consider the fiscal impact that approval of this request would have on the overall operation. The current per diem reimbursement rates for nursing home care and domiciliary care are $17.05 and $7.30 respectively. Should an excessive number of community visitations, in excess of 96 hours, be approved in a fiscal year, the nursing home administrator is sure to be brought to task by his governing board. Perhaps one might wish to consider permitting each veteran in a nursing home the opportunity of taking a one or two week period of time apart from the nursing home without asking the "for profit proprietary homes" to subsidize this vacation. Although our nursing homes provide an outstanding services to the veteran community, the 96 hour rule impedes them from permitting the aged veteran from spending a reasonable period of time with his spouse, son, daughter, or other loved one.

To reconcile the above, I offer the following for your consideration:

1. Provide Federal tax relief to those veterans or the family of a veteran who are willing to care for a veteran who would otherwise be institutionalized. Proprietary nursing homes presently receive VA reimbursements of $60.00 per day to provide nursing home care. In addition, the 1984 nationwide per diem rate to maintain a nursing home patient in a VA environment was $106.15. By allocating a portion of that amount to the family of an aged veteran in the form of a tax rebate, it would improve the quality of life of the individual and would prove to be far more cost efficient. At the same time, it would subsidize the family which could then afford to purchase the services of a home health nurse or aide during normal working hours when both the husband and wife with an aging veteran parent might be required to work. The families with two bread-winners could continue to work and would only be required to provide assistance to their loved ones after working hours and on weekends.

2. Once the veteran's physical condition warrants placement in the nursing home, this should not result in his losing his family identity. The patient should be permitted to take extended home visitations. An increase in the 96 hour rule would afford the veteran an opportunity to remain in the family environment for a more reasonable period of time. Many residents in our nursing facilities throughout the United States would avail themselves to this option should it exist.

3. Lastly, some thought should be given to discouraging the VA from building additional VA nursing facilities and rather divert these funds to the states so as to provide the incentive necessary to insure that each of the 50 states participates in a State veteran's nursing home program. With proprietary per diem costs approaching $60+ per day and VA per diem rates in excess of $106.00 per day, it is certainly far more cost efficient to encourage State expansion of the nursing home programs at the present $17.05 per diem reimbursed rate. Further, Title 38, U.S.C. 5031-5037 (as amended) authorizes the VA to participate in up to 65% of the cost of new nursing home construction. By increasing both the funds available to the VA for this purpose and permitting them to assume a greater percentage of the construction costs of new facilities, it would permit the states and the VA to provide services to a greater number of aged veterans more efficiently and at the same time, will provide some relief to those increased number of veterans who will be vying for the limited number of nursing care beds required between now and the year 2000.

What is clear to this author is that some serius consideration should be given to these issues before the World War II veteran begins to seriously impact on the nursing home waiting lists.

I would like to thank the members of the committee for the opportunity of addressing this distinguished body, and I would hope that my contribution today would in some small measure assist you in successfully meeting the challenges of the future.

Mr. Saxton. Dr. Friedman, thank you very much for what is obviously a very thoughtful testimony, that I am sure will be very helpful to us. I do have some questions for you, but, we will wait until a later time, following the panel's testimony.

Bob Mussari. Bob is the assistant supervisor, Disabled American Veterans Organization.

STATEMENT OF ROBERT J. MUSSARI, ASSISTANT SUPERVISOR, DISABLED AMERICAN VETERANS, NEWARK, NJ

Mr. Mussari. Thank you very much, Mr. Chairman, distinguished members of the committee.

One of the key problems faced by older veterans in obtaining VA care is initially meeting the eligibility requirements for treatment or admission to VA facilities. Many of the older veterans have conditions which require care, but which earn them only the lowest priority of care. For example, a veteran seeking admission to a VA nursing unit, whose disabilities are not service-connected, and who has not been hospitalized by the VA, is placed in the lowest of six priority categories.

These priorities are: One, veterans receiving hospital or domiciliary care in VA facilities when transfer is required for service-connected or adjunct disabilities and persons being furnished care in armed forces hospitals who will require a protracted period of nursing home care upon release therefrom and will become veterans on discharge from active military duty.

Two, veterans not hospitalized or domiciled by the VA, who require nursing home care for service-connected or adjunct disability.

Three, veterans with a service-connected disability, who are receiving VA hospital care and require nursing home care for nonservice-connected disabilities.

Four, veterans with a service-connected disability not hospitalized by the VA, who require nursing home care for a nonservice-connected disability.

Five, veterans receiving hospital or domiciliary care in VA facilities whose transfer is required for a nonservice-connected disability.

Six, veterans not hospitalized or domiciled by VA, who require nursing home care for nonservice-connected disabilities.

More and more veterans seeking assistance fall into this sixth category. I recently spoke to the wife of a veteran who requested the assistance of the Disabled American Veterans in obtaining care for her veteran husband. He was 63 years old, World War II combat veteran, who required hospitalization in a community hospital in the latter part of 1984. Following his discharge from the community hospital, the veteran's condition deteriorated. She took her husband to the nearest VA facility, thinking they would provide the necessary care. According to the wife, they did not admit the veteran because an eligibility clerk stated that he had to be dying before he could be admitted. The VA finally got the veteran placed in a community nursing home, but that only delayed the real problem. The veteran not only received the bill from the ambulance service, but after a 3 month stay, he and his wife could no longer pay their portion of the bill not covered by Medicare. At home, the veteran was unable to care for himself, and his wife, who is 67, is severely disabled by a stroke. He has been placed back in a nursing home that, according to his wife, is not fit for human or animal habitation. The wife is bitter with the Veterans' Administration and vows never to take him back there because, in her words, they just do not care about older veterans.

This is an isolated incident where a growing population of elderly veterans has already crippled the system, and many veterans found ineligible for VA nursing home care have no choice but to turn to the welfare system for assistance. In most instances, placement is made in a nursing home that falls well below the VA minimum standards for such care. Quality health care in these kinds of facilities is virtually nonexistent. Some of the long waiting lists have disappeared for VA nursing homes, but only because the VA has made it tougher to get on the list in the first place.

The VA now screens applicants for admission to its hospital nursing care unit to determine whether or not they have rehabilitation potential. If the screening committee determines an individual does have potential for rehabilitation and that it can be accomplished in 3 or 4 months, the individual is admitted and provided with the necessary services in order to return him to the outside environment.

Long-term nonacute medical patients, who need simply nursing care and domiciliary care are not being admitted to VA nursing homes or units, but are being referred to outside sources. The VA, in some instances, has been placing these individuals in community nursing homes on a 6-month VA contract. Upon expiration of this contract, these individuals are forced to find for themselves funding to continue their nursing home care. The veteran and his family contact our office and ask, what will we do after 6 months. Answering that question, in most cases, is impossible.

The budget reductions that are taking place in different social programs and in the VA system are simply making the poor poorer and the sick sicker. The disabled American veterans would like to see a reasonable budget to take care of veterans, especially health care, for aging veterans, and development of geriatric research programs to further evaluate this growing concern, and to make sure that these veterans, when the time comes, will be able to receive the best treatment and nursing care that this country can provide. Future budget adjustments will be needed to administer this growing veterans program. Quality health care is a must. We cannot stand by and watch the VA stop some vital hospital services and close wards in our hospitals.

The future is here for our aging veterans population. I ask you, is the needed medical services and nursing home services available?

I thank you very much.

Mr. SAXTON. Thank you very much. Dr. Thaddeus Leoniak. This is a particularly interesting bit of testimony. The doctor is a member of the Veterans' Administration Clinical Task Force here in Ocean County, the task force looking into the possibility of extended care and various types of care for the veterans population in Ocean County and in south Jersey.

Doctor?

STATEMENT OF DR. THADDEUS LEONIAK, MEMBER, VETERANS' ADMINISTRATION CLINIC TASK FORCE, BRICK TOWNSHIP, NJ

Dr. **Leoniak**. Thank you.

This text represents my feelings about the plan to locate a veterans out-patient clinic in Ocean County and should be considered in support of better access to health care for the veterans. My thoughts are a product of careful consideration from the perspective of one who is directly involved in the delivery of health care. As an ophthalmic surgeon practicing in Brick, I service a large number of geriatric patients, many of whom are veterans. There is no question in my mind that many elderly people, because of infirmities that prohibit them from driving or finding suitable and economic public transportation, have difficulty in traveling to obtain medical services. This is compounded when the veteran is forced to travel long distances to out-patient services and the VA hospitals located at East Orange, Lyons, Philadelphia, or the VA clinic in Newark.

If the Veterans' Administration feels that they can provide easier access to health care for the veterans in Ocean and surrounding counties by placing a satellite out-patient clinic in Ocean County, I will support the concept. However, I must consider this concept as a pragmatist, and assess it in terms of what is economical and what is really best for the veterans.

The following comments are made in order to provoke some thinking about how and in what context could medical services best be dispensed to the veteran. These thoughts are governed by my philosophy that traditional medical clinics suggest bureaucracy, ergo bureaucracies tend to become expensive and inefficient.

To provide the best possible medical service to the veteran with the least amount of inconvenience to him and cost to the VA, it is necessary to explore all rational possibilities. All good solutions to difficult problems are governed by compromise which raises the following questions: Do all or any of these services have to be provided in a fixed, freestanding clinic facility erected and owned by the VA? Is it possible that these medical services can be provided through a combination of health care delivery systems? For example, contracting with the existing care providers, both hospitals and physicians in the Ocean County service area, and reserving those services peculiar to the veterans, such as social services, day treatment centers, admission screening and public health nursing for our freestanding VA clinics.

I am a member of a task force that is designed to lobby for placing a satellite veterans out-patient clinic in Ocean County, focusing on, but not exclusively, the use of the Brick hospital zone. The task force was conceived by Brick mayor, Hon. Daniel F. Newman, and is chaired by Township business administrator, Mr. Steven Leone. Membership of the task force consists of township officials representing veterans organizations and administrator of the Northern Ocean Hospital System.

The task force was organized in response to the Veterans' Administration 1984 annual assessment of its health care delivery system, compiled from data and recommendations contained in a study called MEDIPP. That's the medical district-initiated program planning, submitted by each of the 28 VA medical districts. The MEDIPP process includes a consideraticn of such factors as accessibility to VA health care for the greatest number of veterans in a given area, distance to existing VA medical facilities, and the size of the current and projected veteran population in a given area. New Jersey is in medical district four, which includes the eastern half of Pennsylvania and Delaware. The fiscal year 1984 MEDIPP submission from medical district No. 4 have identified a need for the location of a VA clinic in the Ocean County service area.

The Ocean County service area is defined in two ways: first, the Ocean County service area includes all veterans who use VA services and who reside in Ocean, Monmouth, Burlington, Mercer, and Atlantic Counties. And, second, the veterans who reside only in Ocean County.

The VA methodology used to recommend an outpatient clinic in Ocean County represents the expected utilization by volume, according to the following pattern: The veterans outpatient clinic in Ocean County can expect to service 100 percent of the eligible veterans from Ocean and Monmouth Counties, and 33 percent from Burlington, Mercer, and Atlantic Counties. The total projected visits to a VA clinic located in Ocean County will be approximately 52,000 patients per year. The methodolcgy by which you would determine in the MEDIPP study that Ocean County service area, and particularly Ocean County, would best be suited for a satellite outpatient clinic is shown in enclosed documents that I have submitted in my packet, which is labelled Ocean County out-patient briefing packet for Veterans' Administration clinic task force meeting, which is dated March 26, 1985.

The document shows how a point system is used to rank each county into districts. The results of the ranking system shows that of the 22 counties studied, Ocean ranked 2d, Monmouth 3d, Mercer 6d, Burington 8th, and Atlantic 15th.

These contiguous counties rank highest on the point scale, making Ocean County the core county in the Ocean County service area. As a result of this MEDIPP study, the request for funds has been submitted for the fiscal year 1987.

In the MEDIPP study documents for the needs for better access while—while the MEDIPP study documents the need for a better access to medical care for the veterans, it also shows that there will be an increase in utilization of these services, placing an additional financial burden on the Veterans' Administration.

At present, there are 67 services listed in the clinic roster provided by the Veterans' Administration. The text on this point shows examples in graph form that indicate that if the Ocean County clinic was to exist, providing all of these services, that the increased useage would be estimated to be enhanced by a factor of five. The rationale to assume the increased utilization is based on the experience of veterans who currently use the VA services. The use of VA health services depends on the proximity, cost, and type of service needed.

Nationally, only 12 to 15 percent of all veterans use VA health care services. If clinical services are provided in Ocean County, the volume and mix of services can be expected to vary from the national experience. Current use may represent only those services which are unavailable in their own communities or for which there is a higher cost, that is out-of-pocket expenses, time or transportation.

In light of these estimated increases in utilization, the cost for clinic services will have to be measured against the need for cost containment produced by budgetary constraints. That is, the VA will have to decide what services should be offered in a satellite clinic. The suggestion to reduce dedication of valuable funds to erecting and maintaining expensive medical support services, that is, laboratory, x ray, rehabilitation services, is to make use of existing facilities in the Ocean County area.

At present, the Ocean County—in Ocean County, there are five hospitals. The Southern Ocean County Hospital, the Manahawken, which is a satellite of Burlington County Hospital, the Community Memorial Hospital in Toms River, Tall Timber Medical Center in Lakewood, and Point Pleasant Hospital and Brick Hospital, which are combined to form the northern Ocean hospital system. Each of these hospitals in the last few years have undergone expansion programs to satisfy a perceive basic shortage. This occurs at a time when a third party reimbursement schedule through the DRG system was supplied to reduce patient access to the hospitals for inpatient services in the interests of cost containment. Despite the increasing population in Ocean County, these hospitals have been confronted with excess beds and lower occupancy. The addition of duplication of services has made the hospitals fiercely competitive between themselves, and those in adjacent counties. The opening of Brick Hospital last year placed a strain on Point Pleasant Hospital's inpatient utilization, forcing both hospitals to reduce the number of their available beds. In Point Pleasant, sections of the hospital that were normally used for inpatients are now being converted to outpatient care.

This shift to outpatient care is a universal trend; however, these services, which have traditionally been provided by the hospitals, now compete against the proprietary control facility, such as surgicenters used for outpatient surgery and emergency care centers that reduce hospital emergency room utilization. The net result in the context of decreased inpatient utilization and competitive outpatient services places an economic burden on all the hospitals in Ocean County. It appears that a freestanding VA clinic in Ocean County represents a duplication of existing facilities and does not make a good, economic sense.

The administration of the Northern Ocean County—the northern Ocean hospital system, specifically, those who represent Brick Hospital on the task force, have taken a position that opens the door for negotiations with the VA to make use of its facility.

On the issue of veterans access to health care providers, specifically, physician services, there has been some dialog between the task force and the Ocean County Medical Society. The task force was formed to lobby for the establishment of VA clinic in Ocean County in response to a need that was determined by the VA plan to erect a freestanding facility to which the veterans would go to satisfy their health care needs.

At a meeting of the task force, the representatives of the Ocean County Medical Society aired their views on how health care needs can best be served. Dr. Anthony DeGroat, president of the Ocean County Medical Society, stated the position, in a letter addressed to Congressman James Hogg, who is a supporter of this VA clinic.

At the expense of going into the details of the letter, just to summarize it, what he calls for is the utilization of existing physician services in the area through the leniency of the—establishing a leniency in the access to these physicians through a voucher system.

The county medical society position was taken into consideration at a task force meeting, where Mr. Jay Halpern, district 4 coordinator for medical affairs, spoke about the budgeting for proposed clinics. He stated that the VA is operating under severe budgetary constraints. Requests for funds for the clinic had been submitted. However, the approval for such funding may not be realized for several years.

He suggested that the movement to obtain the funds for a clinic be continued, but the manner in which the medical services are applied can vary depending on what is appropriate to satisfy the needs.

For example, he made reference to other communities where nonprofit health care providing groups contract with the Veterans' Administration to provide medical services to the veterans. The concept could be incorporated, could incorporate the use of existing support services; that is, Brick Hospital and the local physicians.

This approach could service—could serve as an interim step toward establishing a freestanding veterans clinic that would override and interface with these contracting agencies. The concept is currently under consideration by the Ocean County Medical Society and the VA clinic task force.

In summary, there is a need for providing easier access for the veteran in Ocean County service outpatient health services. It is well documented. The manner in which these services will be rendered is largely controlled by the consideration of economic and efficient dispensing of medical care.

The solution to this problem will become a matter of good judgment, exercised by those who are responsible for providing the funds and those who are providing the services.

This document is designed not to be conclusive, but, instead, to raise questions in order to avoid the dogma associated with narrow and unimaginative thinking.

Thank you.

[The prepared statement of Dr. Leoniak follows:]

Prepared Statement of Dr. Thaddeus R. Leoniak, Member, Veterans Administration Clinic Task Force, Brick Township, NJ

This text represents my feelings about the plan to locate a Veterans Outpatient Clinic in Ocean Count and should be considered in support of better access to health care for the veteran. My thoughts are a product of careful consideration from the perspective of one who is directly involved in the delivery of health care. As an Ophthalmic Surgeon, practicing in Brick, I service a large number of geriatric patients, many of whom are veterans. There is no question, in my mind, that many elderly people, because of infirmities that prohibit them from driving or finding suitable and economic public transportation, have difficulty in traveling to obtain medical services. These problems are compounded when the veteran is forced to travel long distances to outpatient services in the VA Hospitals located at East Orange, Lyons, Philadelphia or the VA Clinic in Newark.

If the Veterans Administration feels they can provide easier access to health care for veterans in the Ocean and surrounding counties by placing a satellite Outpatient Clinic in Ocean County, I will support the concept. However I must consider the concept as a pragmatist, and assess it in terms of what is economical and what is really best for the veteran. The following comments are made in order to provoke some thinking about how and in what context could medical services be best dispensed to the veteran. These thoughts are governed by my philosophy that traditional medical clinics suggest bureaucracy, ergo bureaucracies tend to become expensive and inefficient.

To provide the best possible medical service to the veteran, with the least amount of inconvenience to him and cost to the VA, it is necessary to explore all rational possibilities. All good solutions to difficult problems are governed by compromise, which raises the following questions. Do all or any of these services have to be provided in a fixed, freestanding clinic facility, erected and owned by the VA? Is it possible that these medical services can be provided through a combination of Health Care Delivery Systems? For example contracting with existing Health Care providers, both Hospitals and Physicians in the Ocean County Service Area and reserving those services peculiar to the veteran, such as Social Services, Day Treatment Centers, Admission screening and Public Health Nursing, for a free standing VA Clinic.

I am a member of the Task Force that is designed to Lobby for placing a satellite Veterans Outpatient Clinic in Ocean County, focusing on, but not exclusively, the use of the Brick Hospital zone. The Task Force was conceived by Brick Mayor, Honorable Daniel F. Newman and is chaired by Township Business Administrator, Mr. Stephan R. Leone. Membership of the Task Force consists of Township officials, representatives of Veterans Organizations and an Administrator of the Northern Ocean Hospital System. A complete list of the Task Force members is enclosed. Enclosure No. 1.

The Task Force was organized in response to The Veterans Administration 1984 annual assessment of its health care delivery system, compiled from data and recommendations contained in a study called MEDIPP (Medical District Initiated Program Planning), submitted by each of the twenty-eight (28) VA medical districts. The MEDIPP process includes a consideration of such factors as accessibility to VA health care for the greatest number of veterans in a given area, distance to existing VA medical facilities, and the size of the current and projected veteran population in a given area. New Jersey is in Medical District IV, which includes, the eastern half of Pennsylvania and Delaware. The FY 84 MEDIPP submission from Medical District number IV have identified a need for the location of a VA Clinic in the Ocean County Service area.

Ocean County Service Area" includes all veterans who use VA services and who reside in Ocean, Monmouth, Burlington, Mercer and Atlantic Counties; and second, the veterans who reside only in Ocean County. The VA methodology used to recommend an outpatient clinic in Ocean County represents the expected utilization by volume according to the following pattern. A Veterans Outpatient Clinic in Ocean County can expect to service 100% of the eligible veterans from Ocean and Monmouth County; and 33% from Burlington, and 33% from Burlington, Mercer and Atlantic Counties. The total projected visits to a VA Clinic located in Ocean County would be approximately 52,000 patients per year. Refer to the enclosed chart provided by Mr. Jay Halpern, District IV Co-ordinator from Veterans Affairs. Enclosure no. 2.

The methodology by which it was determined in the MEDIPP Study that "the Ocean County Service Area" and particularly Ocean County would best be suited for a satellite Outpatient VA Clinic is shown in the enclosed document, (enclosure no. 3) labeled Ocean County Outpatient Briefing Package for Veterans Administration Clinic Task Force Meeting, March 26, 1985. The Document shows how a point system is used to rank each county in the district. The results of the ranking system shows that of the 22 Counties studied, Ocean ranks 2nd, Monmouth 3rd, Mercer 6th, Burlington 8th and Atlantic 15th. These contiguous Counties rank highest on the point scale, making Ocean the core county in the "Ocean County Service Area".

The 84 MEDIPP study on Outpatient Services has culminated in a request for construction funds by VAMC East Orange that is addressed in PRF No. 137 and related to Action Number 04-561-032. Construction funds are requested in FY-87. This project was proposed by the District Executive Council in Medical District Four. See enclosure no. 4.

While the MEDIPP study documents the need for better access to medical care for the veteran, it also shows that there will be an increased utilization of these services; placing an additional financial burden on the Veterans Administration.

At present there are 67 services listed in the Clinic Roster provided by the Veterans Administration, (see the attached lists of Clinic services, labeled items number 1 and number 2.) Item number 1 is a list of clinic services utilized by the veteran population from the Ocean County Service Area. It also shows the frequency and per cent that each service is utilized. Item number 2 shows the same list of services but demonstrates an estimated inflation utilization of services, if these services were located in and made available to the entire eligible veteran population in the Ocean County Service Area. The increased usage is based on an estimate that the current utilization would be multiplied by a factor of 5. The rationale to assume the increased utilization is based on the experience of veterans who currently use VA services. The use of VA Health Care Services depends on the proximity, cost and type of services needed. Nationally only twelve (12) to sixteen (16) per cent of all veterans use VA Health Care services. If clinic services are provided in Ocean County the volume and mix of services can be expected to vary from the national experience. Current use may represent only those services which are unavailable in their home community or for which there is a higher cost, (out-of-pocket, time or transportation).

If these estimated increases in utilization of services is accurate and if the VA has assigned a dollar value per visit for each Clinic Service, there will be a marked increase in expense applied against the Veterans Administration. The estimate frequency of use of outpatient services in the Ocean County Service Area equals the actual current utilization rate times factor of five. For example, if a Veteran from Ocean County visits a Clinic in Newark and it costs the VA one dollar, the same Clinic in Ocean County will probably see that same veteran plus four (4) more causing a net increase of expenses of four (4) dollars.

In light of this estimated increase in utilization, the cost for Clinic Services will have to be measured against the need for cost containment produced by budetary constraints—the VA will have to decide what services should be offered in a satellite Clinic. A suggestion to reduce the dedications of valuable funds to erecting and maintaining expensive medical support services, i.e., Laboratory, X-Ray, Rehabilitation Services, is to make use of existing facilities in the Ocean County Area.

At present in Ocean County there are five (5) Hospitals; Southern Ocean County Hospital, in Manahawkin, which is a satellite of Burlington County Hospital—Community Memorial Hospital in Toms River—Kimball Medical Center in Lakewood—Point Pleasant Hospital and Brick Hospital are combined to form the Northern Ocean Hospital System. Each of these Hospitals in that last few years have undergone expansion programs, to satisfy a perceived bed shortage. This occurred at a time when a thrid party reimbursement schedule, through the DRG System, was applied to reduce patient access to the Hospital for Inpatient Services, in the interest of cost containment. Despite the increasing population in Ocean County, these Hospitals have been confronted with excess beds and lower occupancy. The addition of duplication of services, has made the Hospitals fiercely competitive between themselves and those in the adjacent Counties. The opening of Brick Hospital last year placed a strain on Point Pleasant Hospital's Inpatient utilization, forcing both Hospitals to reduce the number of their available beds. In Point Pleasant sections of the Hospital that were normally used for Inpatients are now being converted for Outpatient Care.

The shift to Outpatient Care is a universal trend. However, these services, which have traditionally been provided by the hospitals, now complete against proprietary controlled facilities such as Surgicenters, used for Outpatient Surgery and Emergency Care Centers that reduce Hospital Emergency Room utilization. The net result, in the context of decreased Inpatient utilization and competitive Outpatient services, places and economic burden on all the hospitals in Ocean County. It appears that a freestanding VA Clinic in Ocean County represents a duplication of existing facilities and does not make good economic sense.

The Administration of the Northern Ocean Hospital System, specifically those who represent Brick Hospital on the Task Force, have taken a position that opens the door for negotiations with the VA to make use of its facilities.

On the issue of the veteran's access to Health Care providers, specifically physician service, there has been some dialogue between the Task Force and the Ocean County Medical Society. The Task Force was formed to lobby for the establishment of a VA Clinic in Ocean County, in response to a need that was determined by the VA plan to erect a free standing facility, to which the veterans would go to satisfy their health care needs.

At a meeting of The Task Force, representatives of the Ocean County Medical Society aired their views on how the veterans health care needs can best be served. Doctor Anthony DiCroce, President of the Ocean County Medical Society, states the

Society's position as it is worded in his correspondence to Congressman James J. Howard, a supporter of the VA Clinic in Ocean County. The following is an excerpt from Doctor DiCroces' letter:

We would like to state that we did not initiate or intend to maintain a crusade against VA clinics in any way, shape or form. We were asked by a local group to support a new local clinic and we simply stated our viewpoint. For clarification thereof, we would like to submit the following thoughts to you for your edification and consideration.

We sincerely believe that the veterans (except for those with certain severe service connected disability) could be efficiently and less expensively handled by a local doctor and hospital in his own geographical area.

This concept would produce the following results:

(a) The problem of transportation time for the veterans and their families would be eliminated,

(b) It would give the veterans a "permanent" doctor instead of revolving door array of physicians that they encounter at the VA clinic.

With absolutely no reflection on the quality of care given it is simple logic that familiarity with a patient's condition generally leader to better care.

(c) Considerable reduction of "waiting time", a major complaint of all veterans I have spoken with.

(d) Hospitalization of a veteran at a local facility where the family could conveniently visits him would appear to be preferable to a family traveling one or two hours daily to a VA hospital (to which the clinic would refer) and save on motel charges, gas, etc.

(e) We also believe that the cost of care would be substantially less and I enclose for your perusal a VA study done which showed that the cost of visit per patient is double and triple the cost of private care.

(f) According to a recent AMA article the budget cut will be applied to some types of veteran benefits and if indeed this happens, the veterans will be getting less.

It appears to us that using a private physician at substantially less cost would enable the veterans to get more care for the same money or the same care for less money. Add to this, the cost of opening a new facility with its duplication of laboratory and x-ray facilities and one can see that the savings would be substantial.

If the new facility opened in Brick to serve as far west as Trenton and Camden and as far south as Long Beach Island for example, it would still require the veterans from those areas to drive one to one and a half hours. It would only alleviate the traveling time for those veterans in the immediate area of the new facility and similar situations would apply to any other given area chosen.

The only change that would have to occur is a more lenient voucher system enabling vetrans to choose a local facility and contract for payment by the government similar to Champus.

In summary we feel the above considerations, if applied, would benefit all parties including veterans, their families, hospitals and physicians, especially in view of the glut of hospitals beds and physicians which is developing and which will increase. It seems that the aforementioned suggestions will effect substantial savings to the government, i.e., the people."

The County Medical Society's position was taken into consideration at a Task Force meeting where Mr. Jamy Halpern, District IV Coordinator for Medical Affairs spoke about the budgeting for the proposed Clinic. He stated that the VA is operating under severe budgetary constraints. Request for funds for the Clinic have been submitted for FY-87. The approval for such funding may not be realized for several years. He suggested that the movement to obtain the funds for a clinic be continued but that the manner in which the Medical Services are applied can vary depending on what is appropriate to satisfy the need. For example he made reference to other communities where non-profit health care provider groups contracted with the Veterans Administration to provide medical services to the veteran. This concept could incorporate the use of existing support services, i.e., Brick Hosptial and local Physicians. This approach could serve as an interim step toward establishing a freestanding Veterans Clinic that would override and interface with these contracting agencies. This concept is currently under consideration by the Ocean County Medical Society and the VA Clinic Task Force.

In summary, the need for providing easier access for the veterans in the Ocean County Service Area to Out-Patient Health Services is well documented. The manner in which these services will be rendered is largely controlled by the consideration of economics and efficient dispensing of medical care. The solution to this problem will become a matter of good judgment exercised by those who are responsible for providing the funds and those who provide the services. This document is designed not to be conclusive but instead to raise question in order to avoid the dogma associated with narrow and unimaginative thinking.

Mr. **Saxton**. Thank you very much, Doctor. The next panelist is Steven Leone, chairman of the Veterans' Administration Clinical Task Force in Bricktown.

This is the same organization, is that correct?

Mr. **Leone**. That is correct.

Mr. **Saxton**. Do you share the same views?

Mr. **Leone**. We share the same basic objectives. We have some differing views as to how to satisfy those objectives.

Mr. **Saxton**. Thank you. Go ahead.

Mr. **Leone**. They are compatible, I assure you.

STATEMENT OF STEVEN LEONE, CHAIRMAN, VETERANS' ADMINISTRATION CLINIC TASK FORCE, BRICK TOWNSHIP, NJ

Mr. **Leone**. Congressmen, Mr. Chairman, Congressman Tauke, and Congressman Smith, I want to thank you on behalf of the task force for inviting us here today, and also to my friend and colleague, Bob Zehntner, Ocean County Veterans Bureau, who allowed me to take this seat here in order to make these remarks. I appreciate that. We share also the same views and Mr. Zehntner has been very instrumental and helpful to the task force in furthering the objectives.

I think I have prepared a 15-page statement, which I apologize for submitting late. We did not have the opportunity to send it ahead of us, but it is here for you. I will not read the statement. I will try to summarize highlights of it.

I think that perhaps my job is a lot easier than the others here, in that the task force starts from a point of departure which you congressmen have already laid the foundation for, and that is the fact that an outpatient clinic or additional health care facilities and/or services are directly needed for the veterans of this area, and I define this area as being Monmouth, Ocean, Burlington, Mercer, and Atlantic Counties.

Perhaps there is some debate as to whether or not we are south Jersey, central Jersey or north Jersey, and I guess it depends on whether you are running for office in that particular area at that time and you have constituents in that area.

But, for those from south Jersey, we are from south Jersey, for those from north Jersey, we are from north Jersey, and for those that are not sure, we are in between. Perhaps that is one of the advantages of the fact that this task force is uniquely qualified to address the needs of both south Jersey and central Jersey veterans, because it is centrally located.

It is particularly convenient to the highways of I-95, the Garden State Parkway, and Route 70, and a host of other road networks that bring a lot of traffic and convenience to a site that we will discuss later on.

As I stated earlier, the task force came into being as a result of a report that was issued and mentioned by Mr. Williams and also referred to by Dr. Leoniak, and that is the report of the district four medical planning committee.

In that report, it clearly and unequivocably stated the need for an outpatient clinic in northern Ocean County. The task force itself has focused that need to Brick Township and particularly to the hospital support zone of Brick Township, which is an especially designed zone, created for the sole purpose of encouraging the construction and investment of medical facilities.

We think it is particularly suited for the location of an outpatient clinic because it will be in close proximity to an acute care hospital, the Brick Hospital, and it will be situated in the center of many other kinds of rehabilitation centers, nursing homes, doctors' offices, and, hopefully, other county services that might help the veterans.

The township of Brick and the mayor and council, in particular, together with the support of the freeholders of the Ocean County and the legislative, both Federal, State, and county, have all endorsed the efforts of the task force and have expressed their desire to assist us in any way possible.

So, as I said earlier, our task is perhaps easier in that we are here to help you fulfill what has already been established as a need for veterans' medical care, and I want to assure you that the municipality of Brick Township opens its doors, lends all of its resources, and will support fully an effort to expand those medical services in Ocean County.

I will not go into many of the statistical facts that have been related here because it would be redundant, but I would like to just touch on a couple of points.

First, it has been stated that the veteran population of Ocean County is 152,000 veterans. It has also been related that, and I would like to just give those breakdowns. In Ocean County, there are 47,000 veterans. In Monmouth County, 67,000. In Burlington, 33 percent, or one-third of their population, veteran population, is 16,000. In Mercer County, 12,000, and in Atlantic County, 8,500.

The age breakdown comes in in the following categories: under 35, about 10 percent; 35 to 54 about 40 percent, and 55 and older, the remainder, 49 to 50 percent. So that we see two facts from the age analysis.

First, there is a very substantial number of veterans in the 55 and older today. Second, in the 35 to 54 age group, there is a very substantial number who will turn 55 and older in the years to come.

So that there is a present clear need today and there will be a continuing need in the future years as far as the veteran population of this service area, as previously defined.

During 1982 alone, there were 55,861 outpatient visits to the Veterans' Administration clinic servicing this area. That is 55,861; 71 percent of those were for service-connected illnesses, or 39,740. Again, a substantial and clear need.

Nationally, as Dr. Leoniak indicated, the utilization rate for outpatient and inpatient, I believe, services, veteran services, is 12 to 15 percent. In the service areas defined here, we have interpolated and calculated that the utilization rate is somewhere between 4.86 percent to 6.48 percent, or 60 percent below the national average.

Now, I guess you could say that is because, thank God, we have a lot of healthy veterans, but I think that is not the case. I think the case is clearly one of convenience, of supply or availability. The veterans of this area have to travel some 2 hours each way to utilize veterans services, so that is a 4-hour transportation trip, and then they have to wait from 3 to 6 hours at the clinics to make the various visits.

So, in essence, it is a day's journey, and for a veteran who is ill, who is perhaps suffering from some psychological disorder, or some drug, or alcohol disorder, I think the fear alone of taking that 1-day journey is probably as much a diminishing factor as going for the treatment itself.

So, I suggest to you that the statistics clearly indicate that the hardship imposed upon the veterans is a diminishing and limiting factor for his utilization of medical services that he is entitled to, that he needs badly, and that is not being provided to him because of the inconvenience.

And, as the veteran population grows, and the veteran gets older, the hardships and the inconveniences are going to be greater and greater.

One other thing we looked at, and that was the inpatient medical statistics. I cannot give you specific numbers of patients and numbers of patient days for our service area because it has been difficult to extrapolate that information. However, I can say that based on the statistics that we have been able to look at, the highest frequency of illness falls into the areas of alcohol and drug dependency and abuse, and the second highest area is in mental disorders.

Now, I am a layman, I am not in the medical provider field at all, but based on the little bit of knowledge that I have and that I have spoken to with other professionals, it appears to me that this kind of illness can also be treated on an outpatient basis, and that the inpatient experience has a lot to do with the fact that that is the only way to get the treatment. You cannot travel every day for alcohol abuse or mental disorders to get treated; you have to go in and check in because it just does not make sense to go back and forth every day. So that if there was a facility in far greater proximity, I think you would find two things.

One, as we stated before, higher utilization, and, second, a decrease in the inpatient length of stay as well as frequency of those who are suffering from these kinds of illnesses. So, we will be able to lower hospital costs, we will be able to increase the medical service provided to them, and we will do a tremendous service to the veterans who sorely need these kinds of treatment.

Last, Mr. Williams referred to a document published by the VA in July 1984. I am sure you are familiar with it, "Caring for the Older Veteran," and from what I have been able to read of that document and learn from it, it can be summarized in one simple word. Supply or distance is the answer to better care for veterans, and by that I mean by making a facility more available and in closer proximity, utilization will go up and the veteran will get better care.

We subscribe to that conclusion, and we know you do, and we want to assist you in trying to meet that need. I want to take one moment to just comment on Dr. Leoniak's testimony, and to reemphasize the fact that he is a valuable member of our task force as well as there are other doctors and providers.

We have two schools of thought within the task force; both of them valid and both of them being pursued. One is the traditional approach, which has been supported by the medical report and perhaps you Congressmen and this committee, and that is the way to provide better care more immediately is the establishment of an outpatient clinic.

The second approach is can you provide the program or services that would otherwise be provided by a physical structure through the existing structures that exist in the system. If it can be done, we are all for it. If it is a new pioneering avenue to pursue that would take tremendous legislative effort, we are not willing to wait that long. We like innovation, but the veterans need care today, not 10 years from now, not 20 years from now.

So, the task force is prepared to continue to support both avenues and to assist you in every way possible, and I want to thank you for the opportunity.

[The prepared statement of Mr. Leone follows:]

Prepared Statement of Stephan R. Leone, Chairman, Brick Township Veterans' Administration Clinic Task Force

REPORT OF THE BRICK TOWNSHIP VETERANS ADMINISTRATION CLINIC TASK FORCE

(Stephan R. Leone, Chairman)

Introduction.—In November of 1984, an article appeared within a local newspaper indicating that the most recent report of the Mid-Atlantic Medical Planning Group for the Veterans Administration contained within it a recommendation to the Director of the VA to locate a satellite clinic within the central part of New Jersey, specifically within the Northern Ocean County area. This recommendation, contained within an annual plan submission called the Medical District Initiated Program Planning (MEDIPP), was based upon such factors as accessibility to VA facilities for the greatest number of veterans in any given area; the distances to existing facilities; the size of both the current and future veteran population in a given area; and the current utilization rates for Va facilities in these areas.

The Honorable Daniel F. Newman, Mayor of Brick Township, read the article and immediately initated action to bring the MEDIPP recommendation to fruition. Mayor Newman had long been working under the assumption that the responsibility for addressing the needs of veterans was not simply a matter to be addressed by the State and Federal Governments, but was also a matter to be addressed by any local official who took into consideration the needs of veterans as human beings. It was Mayor Newman's conviction that the veterans entitlement to services was derived from his/her willingness, at a time of national need, to subjugate his/her individual and personal needs and desires to those of the greater national good, and furthermore to be willing to risk life and limb in manifesting this commitment.

Despite the fact that no tax revenues would be generated from such a facility, it was Mayor Newman's future conviction that Brick Township would be an ideal location for the placement of a satellite clinic, and that all of the resources at the disposal of the Township should be mobilized to bring the vacility to the area. This advocacy was based on several factors, among them the following:

The need indentified by the Mid-Atlantic Planning Group for such a facility, and the recommendation within the MEDIPP report that the facility be located within Northern Ocean County;

The residency of over 100,000 veterans within the Ocean and Monmouth County area, Monmouth County bordering on the northwestern and northeastern boundry of Brick. Included within this veteran population are literally thousands of senior citizens, who constitute one of the single largest population groups in the area;

The geographical location of Brick Township and its easy accessibility from other areas of the State, i.e., the Garden State Parkway cuts through portions of Brick, as well as the Major Routes 35, 70, and 88, in addition to the approximately six (6) miles from Brick's border, and which feeds directly into the Parkway;

The extreme hardship being placed upon veterans in traveling to and from the VA facilities located in Newark and Philadelphia, and who must then often wait several hours for services, and all of this is on top of the fact that more often than not those veterans making the journey are ill and/or injured to begin with;

The existance in Brick of a unique concept manifest in the Hospital Support Zone. Created by ordinance, the Hospital Support Zone surrounds the newly created 100 bed acute care facility operated by the Northern Ocean County Hospital Systems, and is designed to encourage the development of medically related facilities and services such as doctor's offices, rehabilitation centers, life and care nursing home facilities, pharmaceutical and medical supplies facilities, and the like.

Not only would the location of the VA facility mean that a holistic approach to health care for the veterans be possible, not no zone approval would be necessary, and sites would be available for purchase, or possibly donation.

In consideration of all these factors, Mayor Newman took action and recommended to the Township Council that a strong, concerted, affirmative effort be made to bring the facility to Northern Ocean County, and to Brick specifically. Upon consideration, the Council shared the Mayor's advocacy, and quickly passed a formal resolution pledging the full support and cooperation of the Township to this effort, and placing Municipal commitment to this effort. Mr. Stephan R. Leone was appointed to Chair this Task Force and Council President Charles Anderson appointed himself, Councilman Warren Wolf, and Councilman Ed Hibbard as members.

THE VA CLINIC TASK FORCE

Born of the Governing Body's commitment to bring the recommended facility to Brick, the Task Force took up the gauntlet on behalf of the Township, and of the numerous veterans residing in the area. The composition of the Task Force was solidified, and included representatives of veterans organizations, physicians, and eventually representatives of various legislative and governmental offices. The current membership roster is as follows:

TASK FORCE COMMITTEE

Stephan R. Leone, Chairman; Charles Anderson, Council President; Emund Hibbard, Councilman; Warren Wolf, Councilman; Nicholas G. Lorris, Vietnam Veterans Leadership Program; Thaddeus R. Leoniak, M.D., N.J. National Guard; Charles Kosanke, Commander Ocean County Ex-Pow; Kenneth C. Eith, Representative VFW Post No. 8867; Robert Shannon, Commander, Arrowhead Memorial Post No. 5698; Stuart Zuckerman, D.O.; Joseph DeFilippo, Administrator, Brick Hospital; Robert Zehnter, Director, Veterans Service Bureau; Jerry Monroe, Blind Veterans; John Thomas, Advisory Aide to Senator Lautenberg; Glenn Ruskin, Advisory Aide to Congresswoman Howard; George Brogan, Ocean County Health Department; George H. Buckwald, Freeholder; Bill Bradley, Senator; and Rodford W. Brindley, Jr., N.J. National Guard.

Charged with the responsibility to advocate for the location of the VA facility, the Task Force sought to clearly and convincingly present the Township case, and to communicate the Township's position to all appropriate individuals and agencies.

The initial meeting of the Task Force took place on January 15, 1985 with other meetings taking place on February 5, and March 26, 1985 with a planning session held on June 10th. Research was done to establish a statistical data base, and the position of the Task Force was communicated to numerous local, county, state, and federal agencies and offices. To date, expressions of support for the work of the task force have been received from the following legislative offices.

Senator Bill Bradley; Senator Frank R. Lautenberg; Congressman James T. Florio; Congressman Christopher H. Smith; Congressman Jim Saxton; Congressman Matt Rinaldo; Congressman Marge Roukema; Congressman Frank J. Guarini; Congressman Dean Gallo; Congressman James T. Howard; Congressman Jim Courter; Congressman Robert A. Roe; Congressman William J. Hughes; Congressman Robert G. Torricelli; Congressman Bernard J. Dwyer; Congressman Peter W. Rodino, Jr.; NJ State Senator John F. Russo; NJ Assembly Majority Leader John Paul Russo; NJ Assemblywoman Marlene Lynch Ford; NJ Assemblyman John Doyle; and Ocean County Board of Chosen Freeholders.

Also, organizational support for the work of the Task Force has been received from the following: Vietnam Veterans of America—Shore Area Chapter; Vietnam Veterans Leadership Program; VFW Post 22226; VFW Post 8867; The Northern Ocean Hospital System Inc.; Allied Veterans Council of Lakewood; Ocean County Ex-Prisoners of War; Arrowhead Memorial Post No. 5698; Ocean County Veterans Service Bureau; Ocean County Health Department; Blind Veterans Organization; Barbara L. Greco, D.D.S.; and Dr. Stuart Zukerman, Professor of Psychiatry.

Also, a petition drive was recently begun and in a very short period of time, some 1,700 signatures of county residents have been obtained. As this is an ongoing effort the Task Force anticipates obtaining many more signatures of support.

STATISTICAL PROFILE

According to 1980 figures, there were approximately 949,500 veterans living in New Jersey. Broken down according to age, the 1980 veteran population of New Jersey would be as follows:

NEW JERSEY VETERAN POPULATION BY AGE, 1980

Age	Numbers in thousands	Percent of veteran population	War veterans	Percent of veteran population
Under 20	2.0	0.21		
20-24	20.0	2.10	7.0	0.87
25-29	37.7	3.97	32.3	4.02
30-34	98.5	10.37	95.0	11.84
35-39	79.6	8.40	50.9	6.34
40-44	80.1	8.43	22.3	2.80
45-49	116.3	12.24	95.4	11.90
50-54	142.7	15.02	137.3	17.12
55-59	158.0	16.64	156.6	19.53
60-64	109.0	11.50	107.4	13.40
65-69	52.9	5.60	50.6	6.31
70-74	25.1	2.65	22.6	2.81
75-79	9.8	1.03	7.9	.98
80-84	10.9	1.14	10.2	1.30
85 and over	6.7	.70	6.3	.78

OUT PATIENT DATA

We shall present herein our analysis of the methodology utilized by the Veterans Administration for determining the potential location for a satellite clinic. The first step was to determine a "theoretical" Primary Service Area (PSA). Those areas served by an Ocean County clinic location would include the five county area of Ocean, Monmouth, Burlington, Mercer, and Atlantic. It was reasoned that the most realistic inclusion would be to consider all of Ocean and Monmouth and 33% of the remaining three counties as the potential PSA. Therefore, for an Ocean County Clinic location the theoretical PSA would include:

1. 100% of the veteran population of Ocean County.
2. 100% of the veteran population of Monmouth County.
3. 33% of the veteran population of Burlington County.
4. 33% of the veteran population of Mercer County.
5. 33% of the veteran population of Atlantic County.

The projected 1990 Veteran population was then determined, as well as the distance to be traveled from each county to the potential clinic site. Also, the prospective in-patient visitation rate, and then the number of 1990 visits was estimated. The following table depicts these figures.

County	Distance (miles)	1982 veteran population	Projected [1] 1990 veteran population	Out-patient visit rate (per 1,000 population)	Estimated 1990 out-patient visits
Ocean	0 to 24	47,354	42,170	435	18,344
Monmouth	0 to 24	67,705	61,668	435	26,822
Burlingon	25 to 49	50,675	48,168 × 33% = 15,993	190	3,028
Mercer	25 to 49	38,323	35,458 × 33% = 11,699	190	2,243
Atlantic	25 to 49	25,874	23,600 × 33% = 7,788	190	1,494
Total out-patient visits all counties					51,931

[1] We will contend later in this document that the anticipated decrease in veteran population in Ocean/Monmouth may very well be offset by a rapidly increasing population.

The VA then allocated points for a high priority workload, which involves determining the percentage of service connected visists in 1982 to existing facilities serving the veterans of the Primary Service Area (PSA), and then allocating points if it could be determined that more than 59% of the visits were service connected. This is graphically depicted as follows:

ALLOCATION OF POINTS FOR HIGH PRIORITY WORKLOAD

County	1982 service connected out-patient visits	1982 total out-patient visits
Ocean	8,226	12,304
Monmouth	12,065	16,769
Burlington	8,480	12,097
Mercer	5,528	6,543
Atlantic	5,441	8,148
Total for PSA	39,740	55,861

The percentage of Service Connected (SC) visits—39,740 over 55,861 = 71 percent.
71 percent (SC percent) − 50 percent = 21 percent.
21 percent over 50 percent = .42.
.42 × 135 (VA weighing factor) = 57 points for high priority workload.

The next step in the process was to allocate points for "equity" by determining the proposed PSA's utilization rate, and to then determine if the utilization rate falls below the national rate. This was determined per the following chart.

County	1982 vet population	1982 total visits
Ocean	47,354	12,304
Monmuth	67,705	16,769
Burlington	50,675	12,097
Mercer	38,323	6,543
Atlantic	25,874	8,148
Total for PSA	229,931	55,861

PSA Utilization rate—55,861 over 229,931 = .243.
National utilization rate minus PSA utilization rate: .600 − .243 = .357
.357 over .600 equals .595.
.595 x 98 (VA weighing factor) = 54 equity points.

This area we feel is particularly important, for which reason we shall focus on the utilization figures in a bit more detail. The clear implication of the VA figures is that the current utilization rate for Ocean County service area is some 40.5% of the national average. Keeping in mind that fact that the number of visits does not equal the number of patients making visits, i.e., most patients make multiple visits in any given year, we could assume that given the fact that nationally approximately 12%–16% of the veterans population makes use of VA facilities, if 12%–16% of the veterans in the Ocean County service area made use of VA facilities, the utilization rate for this area would approximate the national rate of .600. However, as indicated, the utilization rate is, in fact, 40.5% of the national rate, which means that the percent of area veterans making use of VA facilities in also some 40.5% on national rates or only 4.86%–6.48% of area veterans are making use of VA facilities.

If we project the same methodology to the prospective 1990 visitation rates the statistics are charted as follows:

County (percent)	Estimated 1990 vet population	Estimated 1990 out-patient visits
Ocean (100)	42,170	18,344
Monmouth (100)	61,668	26,822

—Continued

County (percent)	Estimated 1990 vet population	Estimated 1990 out-patient visits
Burlington (33)	15,993	3,028
Mercer (33)	11,699	2,243
Atlantic (33)	7,788	1,494
Total for PSA	139,318	51,931

Projected PSA Utilization Rate—51,931 over 139,318 equals .372.

Assuming a national utilization rate of .600, the Ocean County service area would still be approximately 62% of the national rate, or 744%—9.92% would be using VA facilities.

We shall contend, very shortly, that this is not a function of lack of need, nor is it a function of lack of desire, but is a function of lack of availability. We shall further contend that the changing demographic profile of the veteran, i.e., that fact that the veteran population is rapidly becoming an older American population, could very well mean an even lower future utilization rate than that depicted herein, should the location of VA facilities remain as it is.

To continue, step four in assessing the potential location of a VA satellite clinic involved determining the access and remoteness of the potential clinic site to the nearest VA facility.

Travel time from Ocean County to Philadelphia or East Orange: 1-1.5 hours

45 (VA weighing factor) x .5 (1.5 hrs. −1=.5)=23

Utilizing this methodology, the VA determined that the number two and three ranked counties within the medical district No. 4 area were Ocean and Monmouth respectively. Taken together they formed the basis for recommending the placement of the clinic in the northern Ocean County area.

IN-PATIENT DATA

The Task Force then researched the matter in an attempt to determine a more specific need factor for the Ocean County area. We gathered in-patient data from various sources and recorded the most frequently occurring diagnosis for each age category, and then attempted to determine the average length of stay for each age group and each diagnostic category. In this way we attempted to project potential bed need. These are depicted as follows:

MOST PREVALENT DIAGNOSTIC GROUP BY AGE, JUNE 15, 1983

Age and diagnostic group	Number in group	Number all conditions	Number of all conditions (percent)
Under 35:			
Schizophrenic disorders	2,468	7,467	33.05
Alcohol depend/abuse	1,317	7,467	17.63
Drug depend/abuse	463	7,467	6.20
Other psychoses	432	7,467	5.78
Other nonpsychotic[1]	382	7,467	5.11
34–44:			
Schizophrenic disorders	1,775	6,452	27.51
Alcohol depend/abuse	1,152	6,452	17.85
Other nonpsychotic[1]	450	6,452	6.97
Other psychoses	346	6,452	5.36
Drug depend/abuse	211	6,452	3.26
45–54:			
Schizophrenic disorders	2,093	9,669	21.64
Alcohol depend/abuse	1,092	9,669	11.29
Malignant neoplasms	762	9,669	7.88
Heart disease[2]	435	9,669	4.49
Other psychosis	408	9,669	4.21
55–64:			
Schizophrenic disorders	2,965	22,386	13.24

MOST PREVALENT DIAGNOSTIC GROUP BY AGE, JUNE 15, 1983—Continued

Age and diagnostic group	Number in group	Number all conditions	Number of all conditions (percent)
Malignant neoplasms	2,590	22,386	11.56
Heart disease[2]	1,433	22,386	6.40
Alcohol depend/abuse	1,180	22,386	5.27
Cerebrovascular disease	1,165	22,386	5.20
65–74:			
Malignant neoplasms	1,620	13,008	12.45
Cerebrovascular disease	1,013	13,008	7.78
Heart disease[2]	997	13,008	7.66
Schizophrenic disorders	864	13,008	6.64
Disease of respiratory[3]	840	13,008	6.45
75–84:			
Organic psychotic cond. (excluding alco. & drugs)	334	3,767	9.08
Cerebrovascular disease	334	3,767	9.08
Malignant neoplasms	309	3,767	8.40
Heart disease[2]	293	3,767	7.97
Non-psychotic mental dis.	267	3,767	7.26
85+			
Heart disease[2]	320	2,871	11.14
Organic psychotic cond.	302	2,871	10.52
Other non-psychotic dis.	273	2,871	9.50
Malignant neoplasma	269	2,871	9.36
Schizophrenic disorders	212	2,871	7.38

Footnotes for Diagnostic Group by Age:

[1] Other non-psychotic mental disorders does not include neurotic disorders.

[2] Heart disease includes rheumatic heart, hypertensive heart disease, acute myocardial infraction, other ischemic heart disease, other forms of heart disease.

[3] Other diseases of respiratory system does not include acute infections, pneumonia, influenza, bronchitis, or emphysema.

We would point out that the relatively lower concentration of patients within specific diagnostic categories within the older age brackets is an indication of the greater prevalency of a greater variety of illness, and thus the proportionately greater need for more diverse medical services.

VA Med Cntrs-Hospital Care Component: Average Length of Stay by Most Prevalent Diagnostic Groups for Patients Discharged fiscal year 1983.

Diagnostic Group	Patients	Average days	Median days
Schizophrenic disorders	46,360	97.8	23.4
Alcohol depend/abuse	80,107	24.7	16.1
Drug depend/abuse	10,943	27.2	13.9
Other Psychoses	19,415	49.5	24.9
Other Nonpsychotic mental disorders	18,174	60.5	16.6
Heart disease	96,540	16.82	10.26
Malignant neoplasms	95,806	24.48	13.5
Other diseases of central nervous system	11,940	68.9	14.9
Cerebrovascular disease	23,158	39.2	16.5
Other diseases of respiratory system	45,746	18.2	8.9
Organic psychotic conditions	5,322	156.3	27.4

VA Med Cnts-Hospital Care Component: Average Length of Stay by Age for Patients Discharged FY'83

Age	Number of patients	Average days	Median days
Under 35	112,323	20.37	7.87
35 to 44	100,631	23.85	9.75
45 to 54	146,259	24.05	9.65

Age	Number of patients	Average days	Median days
55 to 64	349,963	24.45	9.80
65 to 74	200,944	26.90	10.25
75 to 84	48,513	35.45	11.45
85 +	38,713	45.20	12.00

Based on these figures we attempted to calculate the approximate bed need for each age category by multiplying the number of patients in each category with the average length of stay for each patient in that category. We then divided the resulting figure by 365 to obtain an approximate daily bed need for each age group. This is graphically depicted as follows:

Approximate Daily Bed Need by Age Based on Average Length of Stay by Age for Patients Discharged FY'83

Age	Number of patients	Average days	Approximate patient days fiscal year 1983	Approximate beds per day
Under 35	112,323	20.37	2,288,020	6,269
35 to 44	100,631	23.85	2,400,049	6,575
45 to 54	146,259	24.05	3,517,528	9,637
55 to 64	349,963	24.45	8,556,595	23,443
65 to 74	200,944	26.90	5,405,394	14,809
75 to 84	48,513	35.45	1,719,786	4,712
85 +	38,713	45.20	1,749,828	4,794

While we were not able to obtain figures concerning the average length of stay, by age, for Veterans of the Ocean County Theoretical PSA, we were able to obtain the average length of stay for inpatients coming from Ocean County only in fiscal year 1984, and of the 592 identified in the data provided by the Veterans Administration for Medical District 4, nearly 70% has hospital stays of over 8 days, with well over 52% having stays of more than 14 days.

The importance of these figures becomes apparent when one considers that the average length of stay for patients in the recently opened acute care facility in Brick Township is 7.5 days, keeping in mind that the proportion of senior citizens in the area is significantly higher than state averages. In short, we would raise the question as to the potential impact on the projected bed need should an outpatient clinic be located in the northern Ocean County area. While we cannot show definitive figures to provide proof for this contention we would nevertheless still contend that the average stay per patient at the hospital care facilities would be significantly lower than it now is.

The relevance of these figures to the theoretical PSA identified earlier becomes more apparent if we approximate the age breakdown of the PSA and then correlate it with the appropriate diagnostic group for each age grouping as well as the average length of stay for each age and diagnostic catetory, and then project an average bed need facility category. Certain methodological difficulties did confront us in determining the age breakdown of the theoretical PSA since it was just that, i.e., a non-existent entity per se. We approximated the age breakdown by first determining the age breakdown for the existing PSA served by the East Orange VA facilities, and then applying, with caution, the percentages of each category to the theoretical PSA for Ocean County. This may be depicted as follows:

Percent breakdown of Veteran Population Served by East Orange VA facilities as of March 31, 1985

Age	Number in grouping	Percent of total
Under 35	73,010	10.28
35 to 44	137,760	19.43
45 to 54	151,770	21.40
55 to 64	213,290	30.08
65 to 74	106,220	14.98

Age	Number in grouping	Percent of total
75 to 84	20,400	2.87
85 +	6,480	.91

The theoretical PSA for Ocean County as follows, using 1982 vet population data as per Medical District No. 4 report:

Ocean County (100 percent)	47,354
Monmouth County (100 percent)	76,705
Burlington County (33 percent)	16,723
Mercer County (33 percent)	12,647
Atlantic County (33 percent)	8,538
Total	152,967

Applying the percentage figures used above, the approximate age breakdown of the theoretical Ocean County PSA is as follows:

Approximate breakdown of veteran population served by theoretical Ocean County PSA.

Age	Number in grouping	Percent
Under 35	15,741	10.29
35 to 44	29,722	19.43
45 to 54	32,736	21.40
55 to 64	46,013	30.08
65 to 74	22,915	14.98
75 to 84	4,390	2.87
85 +	1,392	0.91

To make the figures more immediately applicable to the potential Ocean County PSA, we took the total visits in 1982 to VA facilities noted in the VA planning document and applied the approximate age percentages to determine an approximation of the number of patients in each age grouping. We then took the average length of stay for patients in each category who were discharged in fiscal year 1983 and multiplied this figure with the approximate number of patients in each age grouping. The resulting figure was the patient days in each age category, which we then divided by 365, this resulting in the potential daily bed need for each category. This is depicted in the following chart.

The figures indicate a daily bed need, for all age groups of over ———. Again, we would contend that this figure would be significantly lower if an outpatient clinic were located in the northern Ocean County area more specifically, Brick Township. Again, we point to the fact that the average stay at local facilities is significantly lower than the average stay for veterans at a veterans facility. We introduce the possibility that this is at least in part a function of the distance from the majority of the patient population which necessitates the provision of services in a single descrete time block contingent upon the availability of the patient.

Further, we would contend that this would significantly reduce the cost of service provision in the amount and duration of in-hospital stays would be reduced. And this would also reduce the time and inconvenience, the "non-medical" difficulties in traveling several hours to and from a facility, without benefit of supportive family members during the period of hospitalization.

SUMMARY AND CONCLUSIONS

Again, figures are to be taken in light of the fact that naturally, only 12-16% of the veteran population utilizes VA facilities. The figures presented earlier in reference to the theoretical Ocean County PSA revealed that the utilization rate for this area was significantly below national averages. In projecting future needs one may legitimately ask the question as to the impact and reasons for the low utilization rate in Ocean County area.

An answer to this may be found in the Document published by the Veterans Administration in July 1984 entitled *Caring for the Older Veteran*. In attempting to project the real need for VA health care they define health care as: The level of health care services required by eligible veterans who request VA care or who would do so if they knew of their eligibility and of VA services, and if the services were readily available. (Appendix I, page I-1)

The document then proceeds to convincingly argue that the primary determinant of demand for VA health care services is a readily accessible supply of such services. In summary, it is concluded that "supply accounts for more of the variation" in demand "than everything else combined." (I-2)

Utilizing this data, we would similarly contend that the low utilization rate projected and already manifest in the Ocean County PSA is a function of the remoteness of the existing VA facilities, and not a function of lack of need.

Consider further please the changing demographic profile of the American Veteran. For the existing service PSA's in District 4, an accelerated decline is predicted in the number of veterans, this decline being projected as 7% from 1985 to 1990, another 8% from 1990–1995, another 9% from 1995–2000 and so on. Combined with this is the internal make-up of the veteran population. By 1990 it is anticipated that more than 25% of the veteran population will be over the age of 65, and by the year 2000 this figure will jump to over 33%. Also, veterans over 65 will also constitute a larger proportion of all males over the age of 65 such that by the year 2000 the proportion of all males who are veterans will reach 63%. This means that under the current structure of eligibility, by the year 2000 nearly 2 out of every 3 elderly males in the United States will be eligible for VA medical care if they so choose to make use of such programs.

The previous data cited clearly indicates that if this is the case, the nature and needs of the demand for services, and the types of services demanded will change radically. Concerning the Ocean County PSA we would contend the following:

The projected decline in veteran population will not be felt nearly so much in the Ocean County area given the tremendous population growth of the area. Consider that between 1960 and 1070 the population of Ocean County increased by 92.5%, and between 1970–1980 the increase was 65%.

Consider also the fact that the senior citizen population of the area has also experienced a dramatic increase, until it is now estimated that approximately 30% of the population of the County is comprised of senior citizens.

Given the population profile of the Ocean County PSA it is not altogether unreasonable to assume that the VA statistics will be amplified given the already higher aged population, of the area. One can argue that given associated factors, the need and demand for specialized health care for the aged may very well increase more than the demographic picture indicates. This is due to the fact that not only do older people have more illness, but the illness they do have is complicated by a slower response time to treatment, and the prior existence of other chronic medical conditions. Further, there is a range of non-medical conditions and needs that complicate the situation, these including transportation, housing, and income maintenance.

The Brick Town Clinic Task Force is supportive of the four (4) objective sited in the VA study on the aging veteran, namely: To sustain and be supportive of the older veterans independence, comfort and contentment in his own home environment for as long as possible; To provide those who need them with additional care and attention in residential accomodations; To provide backup hospital accommodations providing skilled medical and/or nursing care during episodes of illness; To assure that each older veteran needs are fully assessed, and that all required services are appropriately coordinated.

We, therefore, strongly support and advocate for the provision of an integrated system of health care which is accessible, available, comprehensive, and provides continuity of care. Supply, or in this case, availability, is seen here as the key variable, with the necessity present for the facility to be placed within the appropriate geographical locale for the majority of patients in need, and, therefore, being in a position to coordinate all of their resources needed to manage the medical and non-medical problems manifest.

We would contend that no more appropriate geographic local can be identified than Brick Township. The location of the clinic is justified by demographics of the PSA population; the medical needs of the population, the non-medical need of the population; the accessibility of the area and an available capability to effectively and efficiently manage the health care and related needs of the older veteran.

No longer would needy veterans who are entitled to services have to travel from 3 to 6 hours round trip for care, and then in many cases have to wait several hours for care, precisely at that point in time, when they are least able physically and/or mentally to make such a trip. We would also contend that the actual hospital stay would be shortened in that testing and/or diagnostic procedures being carried out over a period of days would not require the patient to remain in the area to avoid another 3-6 hours of travel. As shown, actual utilization figures provided by the veteran administration for medical district 4 revealed that more than 50% of inpatients from the Ocean County Service Area remain in the hospital from between 2 weeks to 2 months. We are contending that an appropriately placed facility would shorten the average stay for most patients from the Ocean County Area. This would lessen the burden on family members and other loved ones, who would not be in a position to provide emotional support should they be prevented from visiting patients given the distance and time required in traveling to and from the facility. To repeat, all data indicates that Brick Township would be the most appropriate location within the Northern Ocean County area to place such a badly needed facility. Should the decision be to place a facility in northern Ocean County, specifically Brick, the Task Force would stand ready and able to assist the VA in locating specific property either by purchase or donation.

SOURCE DOCUMENTS

Veterans Administration—Administrator of Veterans Affairs Annual Report, 1983; Caring for the Older Veteran; Description of Services Used by Veterans in the Ocean County Service Area (April 26, 1985); Geographic Districution of VA Expenditures fiscal year 1982, County and Congressional Districts; Ocean County Outpatient Briefing Package for Veterans Administration Clinic Task Force Meeting March 26, 1985; and State Profile of Veterans Population 1980 Census.

Mr. SAXTON. Thank you very much. I would like to thank all of you for very, very thoughtful testimony. It seems to me that the message is very clear in terms of where we are from Dr. Williams, the director of the Philadelphia Veterans Hospital facility. I am, incidentally, personally familiar with your condition there. I know that you are working very diligently with the facilities that you have, and doing a good job, as good as can be expected under the conditions.

As I listened to the testimony, it seemed to me that there were a variety of ideas in terms of how best to solve the problem that we all know exists. There is certainly a need for long-term medical care in hospitals, as well as a need for nursing facilities for veterans, and increased care on an outpatient basis. While there may be some disagreement as to how we get to that, it seems to me that we all agree that there is more needed, and that perhaps outpatient care and home care is an important part of what we ought to be aiming for.

Let me direct just one question to each of you. How do you see it best in terms of our being able to put in place either new facilities or, as Dr. Leoniak would suggest, a different system to use existing facilities, in order to provide for that continuum of care on various levels?

We know we need hospitals. We know we need outpatient clinics. We know there are available medical facilities out there that we can presently use. We know that we could modify perhaps the tax system, as you suggest, to provide an incentive or the ability for people to care for their loved ones at home when they are ill.

What kind of changes do we need to make in order to accomplish those things that you might subscribe to?

Mr. WILLIAMS. Well, I think, as has been mentioned, such a very small portion of the veteran population actually comes to the VA facilities now——

Mr. SAXTON. I think we need to pass the microphone.

Mr. Williams. As has been mentioned several times, there is such a very small percentage of the veteran population that are currently using VA facilities, even the most mild projections as to what the demands could be in the future, there is no way that we can provide all the care in the VA facilities.

So, I think we are looking at the alternatives. We are looking at other ways, specifically, with the elderly veterans, as we mentioned, who now, 60 to 80 percent of them, are already in the home situation. We are trying to look at alternative ways to provide the care they need without institutionalizing them. We are not looking to build more hospital beds and put them in bed or to put people in institutions.

We are trying to find alternative ways to put them out. So, we identified the need, as several have mentioned, that the biggest undermet need is in the southern Jersey, Ocean/Atlantic County area, which is one of the biggest areas we are not meeting the need right now. The other area is north Philadelphia, in Bucks County.

Those two are the most underserved areas in this whole neighborhood. So, we have identified that as our primary focus as to where we need to put some attention. Now, whether it is an outpatient clinic or what it is, we just know that there are services needed by veterans that we are not able to provide just because of the distance.

We look at all the areas, we are not committed just to an outpatient clinic. If there are other ways of doing it, we are looking at the other ways of sharing the community resources and some of the other residential care and hospital-based home care. All we know is that it is an area that we need to focus on and we are trying to find a way to treat the patients and provide for their needs out of the hospital situation, and we do not care how we do it, as long as we do it.

Dr. Friedman. In answer to your question, I think the common theme that I heard this morning, and one to which I totally subscribe to, is home health care or outpatient clinics is obviously, I would think, the thrust for the future. Nursing homes are important and nursing homes or institutionalized care provides a very necessary service.

But, it is not a normal environment. It is not like—it is not where senior citizens sit down and have meals with his loved ones, with his grandchildren, have an opportunity to clean the dishes, talk with the grandchildren and so forth.

I think what we should be looking at into the future is really a combination. Obviously, we do need more nursing home beds. I think the statistics point that out. But, along with that, I think what we should be doing is looking for some type of way to make it affordable and everything always seem to reduce itself to finances.

How do we make it affordable to keep the senior citizens, who are the senior veteran citizens, at home? And, I think if we attack the problem in terms of providing additional nursing beds, but also providing some means, some fiscal means by which we can keep these senior citizens home, I think that would be a two-prong approach which all clinicians in the field would certainly subscribe to.

Mr. **Saxton**. Doctor, in your testimony, you indicated that you felt it would be more cost effective if we had the tax credit system in place to encourage families to take care of veterans at home.

Are there any studies or is there any statistical information that you can point to which we might be able to use to make that point?

Dr. **Friedman**. I am sorry, Congressman, I cannot address my presentation to any particular study, but in terms of the statistics, if you look at the $60 a day the VA is paying for proprietary nursing homes, and if you look at the $106 a day which it currently costs to keep a veteran in a nursing home within the VA system, then you look at the $17.05 which the VA pays to the 42 State nursing homes throughout the country, just on a cost-analysis basis, you can readily see that if some of these funds could be passed back to the community, there would be any numbers then of individuals who might not need institutionalization, where a two-working family—where a two-working-member family, our society today, the husbands and wives work, what do you do with the elderly individual during the day?

We can take care of them as loved ones, we can take care of them at night, we can take care of them during the weekends. However, many of us, both husbands and wives, must work. Provide an outlet for that and you might reduce the nursing home beds which will be needed in the year 2000.

Mr. **Mussari**. Mr. Chairman, the Veterans' Administration was founded on the premise of quality medical care for the veterans of the United States and those who fought in our wars.

One day we can pick up the paper and read about the proposed budget reductions and, then, the next day, we are talking about upgrading treatment for veterans. And, it seems to me that the two groups of people that receive the most direct target for reductions in the budget are the senior citizens, dealing with Social Security benefits, and the Veterans' Administration, in dealing with the overall veterans as far as treatment and compensation benefits, which just recently had to be taxed, and this was stopped, as you are well aware, by the Cranston amendment.

I think we have got to look at it at an overall basis, that we cannot, on one hand, propose increasing the Veterans' Administration budget to give us quality care that we fought for and that we need, and, then, in the next day read in the paper where the proposed reductions in the Veterans' Administration budget dealing with VA benefits and Social Security. It has got to be one way or the other. We need these benefits. We fought for them. We are entitled to these benefits, and I do not think we should have to pick up the paper from day to day and read about the proposed reductions.

I agree here with my colleagues in having a clinic here in the Ocean County area, but if you look at it realistically, how are we going to build a clinic in Ocean County when the VA plans on reducing their overall spending for this fiscal year?

There is no way possible. I mean, we have to look at it where we need that funding, if they are not going to build the clinic here, build it in south Jersey, but, first of all, get us that funding, maintain the benefits that we have, and keep that quality care that we have fought for.

Thank you.

Dr. **Leoniak**. In answering your question, I think I would have to ask a question, and asking us how you could help as legislators.

The thing that impressed me was that when the statement came out the VA was planning on placing a clinic in this area, and that is what I am here to address, I was never able to find out through my research exactly what constitutes a VA satellite clinic.

What I am driving at is it seems to me that it is rather ill-defined as to what the VA actually wants themselves. Perhaps that documentation is somewhere, but I had difficulty finding out what it is.

The reason it is important is because my proposal, which obviously included utilizing existing facilities, may become a moot point, if the VA plans to operate in a vacuum. In other words, put in place a self-contained clinic, self-sustaining in the sense that it has its own people, own technicians and services, so it would be helpful as legislators with any influence on the Veterans' Administration if you would have some input in helping them or helping us to understand more readily what they are looking for.

It struck me, too, that the article came out and it was in a—there was really no—there did not seem to be any contact with the legislators or county or officials as to what the administration was really looking to do. If not for the fact that the task force took the initiative to make contact with the Veterans' Administration, we probably would have never heard anything from them, just the article stating that they planned on putting a clinic.

Mr. **Saxton**. Let me ask you, are you in favor of a clinic in Ocean County, or are you opposed to a clinic in Ocean County?

Dr. **Leoniak**. I am somewhat of a middle-roader. I do believe——

Mr. **Saxton**. Are you running for office?

Dr. **Leoniak**. You taught me a lot of tricks. I really am a middle-roader in the sense that I do believe, as I stated in the text, that there is room for services to be administered by the VA that are germane and particular to the veterans, making use of existing facilities, and also the visiting services that exist in the area.

Mr. **Saxton**. I can appreciate the feeling of people who are involved in the medical profession in this area, particularly in light of the fact that you may have the facilities available to take care of more people. I know that hospitals in this area have been expanded.

Our primary concern with regard to a veterans outreach clinic or veterans outpatient clinic is to provide most immediate service at the highest level that we can. I am not sure that I can, at this point, justify in my mind changing an entire system or initiating a voucher system, which may be a very lengthy debatable pro-and-con type of process, when we appear to be close to at least a partial solution by building a clinic in Ocean County.

I would certainly not want to be in a position for the benefit of the veterans of this area of saying that we are going to begin to look into a new system to provide better long-term care or to provide better care long term, I guess I should say, the whole New Jersey delegation, is together on that one thing. Democrats, Repubicans, north Jersey, south Jersey. We have all been trying to get that clinic, and I would hope that your clinic task force would be very supportive of that endeavor because we think it is important.

Dr. **Leoniak**. If you want to pin me down to a yes or no answer on that question as to whether I am in support of the clinic, the answer is yes, I am supportive of the clinic. There is no question about it.

I would just like to feel that some thinking would go into the establishment of the clinic, which would make it most economical and feasible to operate.

Mr. **Saxton**. Thank you.

Mr. **Leone**. I like this being last each time because I can just say I agree with the Congressmen.

The task force is clearly supportive of the outpatient clinic being established, and so are the veterans of Ocean County, 9,000 in Ocean County and 52,000 in the area.

And, as Mr. Leone has said, some of the medical profession, in that they are dedicated to increasing the care for veterans, they differ as to the best way to do that, and I am sure will come to the realization, as you have just expressed, that the only practical way to do it today is through an outpatient clinic.

As they continue to try to develop more efficient ways and more responsive ways for providing that care, the recognition has to be that an outpatient clinic is the way to do it today.

So far as the budget is concerned, I just want to say this, the capital costs for this clinic are probably the least expensive aspects of the whole program, and if I were to be asked if we thought we could [a] acquire land for a clinic, [b] raise funds to construct the clinic, independent of the Veterans' Administration, I think I would be well to say yes. I think we can do it for you.

The cost of running the clinic is the issue, and that issue, perhaps, is not so bad either because the cost of providing the services at the present clinics will be substantially reduced by providing them locally because of transportation costs, longer stays for in-patient care, and a more convenient location, and then we cannot evaluate the cost—I mean, how do you put a price on the fact that a person does not go for medical services that he needs? Put a price on that. I cannot, and I do not think anybody wants me to. We need a clinic.

Mr. **Saxton**. Congressman Tauke.

Mr. **Tauke**. Thank you, Mr. Chairman.

Mr. Mussari painted a fairly bleak picture of the care available to veterans. Dr. Friedman and Mr. Williams, I am wondering, as directors of veterans institutions, how do you react to the testimony that he offered? Is the picture as bleak as he suggests?

Mr. **Williams**. Hopefully not. We do not see it quite as bleak as—of course, he deals in a situation where a lot of the problems that we are facing do come to him, so maybe he sees most of the problem side of it.

We think that we agree with him as far as the care that we are able to provide to veterans over here in southern Jersey, that we are able to provide the best just because, it has been mentioned several times, the long distances, the fact that the services just are not available to them, and when they get over, there is a long wait.

But, when there are individual cases like this and when there are problems that arise, obviously they do, we like to get in and try to take care of them, and hopefully, try to resolve them. I do not think it is that bleak. We are very optimistic that we are moving in the right direction.

Dr. **Friedman**. I think what we need is a handshake. I think, on the one hand, the State of New Jersey has been very receptive to the needs of the aging veterans inasmuch as we are one of the few states in these United States which has two nursing homes, and, very shortly, in November of this year, we will be opening the first phase of a third facility in Bergen Pines, which will be a 114 bed facility.

I think the real crux, though, is not building more facilities. I think if we are going to paint a more optimistic picture between now and the year 2000, it is going to be necessary to complement the nursing home situation, both VA and state nursing homes, with these home health care or these out-patient clinic concepts.

I think if we leave with nothing else today, it should be that the theme should be that we keep the aged veteran at home for the longest period of time possible. We can do that with the out-patient clinics, and we can do it with the home health care concept.

Overall, I think we have——

Mr. **Tauke**. I am going to get into that because I agree with you on that point, but I am wondering how is it that we have a 63 year old veteran in the condition that he described, who is unable to find care? Is that true in New Jersey or in Iowa, that we have people who are essentially disabled, who need nursing home care, unable to get it?

Dr. **Friedman**. The reality of the situation, Congressman, is this, at the New Jersey Methodist Memorial Home in Menlo Park, our waiting list is, in fact, in excess of 1 year. Roughly one third of the veterans on the waiting list have to wait before they are admitted to the home. Again, the reality of the situation is the only time a bed becomes vacant is when one of my 388 members passes away.

So, to that extent, I do agree, there are many, many veterans out there who are looking for placements. We talk about statistics. These are individuals. Looking for placements and never getting them.

Mr. **Tauke**. So, these individuals then seek private nursing home care, as this gentleman did, as I understand it. They apparently are able to receive some assistance for a 6 month period, and then what happens?

Mr. **Williams**. I think the 6 month period is referring to by law, the service-connected veteran, we cannot place in a community nursing home for an unlimited period of time. By law, we can only out-place the non-service-connected veteran up to 6 months with possibly a 6 months extension.

Now, that is not just as seemed to be implied by the lady's case, that the veteran is dumped out there for 6 months, and then they are on their own. The reason for the 6 months in the first place is to allow us to work with the veteran and his family and the nursing home to make other arrangements for the veteran to be taken care of.

Most of them qualify. If you do not qualify for the VA care, qualify for either Medicare or Medicaid, and the 6 months gives us that period of time to work out with the family other arrangements, so at the time the VA is no longer able to pay, then the family is able to continue with another program. They are no longer ours.

Mr. **Saxton**. Dr. Friedman, you gave some very startling statistics. You stated that it costs the Federal Government, if I understand you correctly, over $100 per day to keep a veteran in a Veterans Administration nursing facility. Furthermore, you report $60 a day is paid to keep a veteran in a proprietary institution, and $17.50 a day is paid to a State, if it has its own nursing facility.

Why in the world does it cost over $100 a day to keep a veteran in a VA facility?

Dr. **Friedman**. I am not sure I am going to be able to answer that question.

Mr. **Saxton**. Well, give me your best judgment.

In the State of Iowa, we reimburse for title 19 patients, about $30 a day for nursing home care. If you have skilled care, you might get $55.

Why in the world is it costing over $100 a day, and I might say this may relate to that question of budgets for the VA? Maybe it is not that they have too little money, but maybe it is in the way it is spent.

Dr. **Friedman**. Well, I might answer that, really, in one of two ways. First of all, the statistic was taken from a VA published journal. The second thing I might suggest to you is this: I think historically over the years, the Federal Government deserves a gold star in the manner in which it collects and disburses moneys through our tax system.

I do not believe, however, and I think the statistics would show, they are not quite as good at running programs. They would not get a gold star in actually running programs in the State. They are much better money changers. Perhaps my colleague might want to add something to that.

Mr. **Williams**. Yes; let me try to clarify that. The $106 that I think you are referring to is if you take the total all inclusive rate, if you take all the costs associated with doctors, nurses, staff, meals, the whole thing of keeping a patient in a VA hospital or a VA nursing home within the hospital environment, which means we have our own staff and all inclusive, the drugs and everything, that is an average that it costs us per day.

It does not mean that in a community nursing home, it only costs them $60 a day to do the same thing we are doing for $106; it just means that whenever we place a veteran in a community nursing home, the only amount of money—the most we can pay that community nursing home to take care of that veteran is $60 a day from the VA.

Now, that is why we have such a difficult time placing them, because it costs the nursing home so much more than that. They do not want to take our patients for just $60 a day, and we cannot get veterans in community nursing homes because they will not accept the rates that, by law, we can pay.

So, it is not that it only costs them $60 a day, it is the $60 is all we can pay, and they will not take it because it does not come near the cost.

Mr. **Tauke**. How much is paid for title 19 patients in New Jersey?

Mr. **Williams**. Title 19 is skilled nursing homes?

Mr. **Tauke**. No, title 19 is an immediate care facility.

Dr. **Friedman**. I know it is more than $60. I know the per diem rates today in the State nursing homes is running anywhere between $55 and $65 a day.

Mr. **Tauke**. For skilled care or——

Dr. **Friedman**. For long-term care.

Mr. **Tauke**. For long-term care.

Dr. **Friedman**. Yes, yes, and I would suggest what my colleague has suggested to the group is not quite accurate. The Federal Government reimburses at $17.05 a day; however, the total cost per patient, as I said, is in excess of $60. It runs somewhere around $62 a day.

Mr. **Tauke**. Now, do you suggest that the Federal Government put more money into encouraging States to, first of all, have a nursing home for veterans? And, second, you suggest that we provide greater reimbursement. Now, are you suggesting that we take money and put it into increasing the $17.05 per diem that we pay, cr do you think we should put it into capital investment and new facilities for the States?

Where should we—if we were going to take money and put it into this program, where would we put it?

Dr. **Friedman**. I am not running for office. I will not suggest both. I think what I might suggest to you is this: there are approximately 13 States which presently do not have any State veterans homes at all. I think the first emphasis should be on encouraging them to open State veteran nursing homes. Obviously, the—either the 65 percent, which is currently being allocated to new construction is insufficient, or possibly, as you might suggest, the $17.05 per diem is not sufficient for the State to have the incentive to create these additional facilities.

I think, first, what must be done, just on a cost effective basis is to get the other 13 States aboard, to have State veteran nursing homes throughout the country.

Mr. **Saxton**. Thank you very much, gentlemen.

Mr. **Smith**. Thank you, Mr. Chairman, and, first of all, I want to commend each and every one of you on your fine statements and answers to several of the questions posed, and Dr. Friedman, I would have to concur with you.

The committee has been looking at this very carefully, and the emphasis should be on State/Federal ventures in the area of nursing homes. We are doing a similar thrust in the area of cemeteries, on the committee, where there is a matching grant, an incentive grant provided, and the State comes in and then assumes at least partial responsibility.

So, I think this aging committee, certainly the veterans affairs committee, concurs with you on that.

You made several recommendations in your testimony, three recommendations, and I would just like to touch on your first recommendation in terms of providing Federal tax relief to those veterans or families of veterans who are willing to care for the veteran at home, home health care initiatives.

The Congress is looking at that very carefully and, as a matter of fact, right now, there are at least two bills that would provide such assistance to the entire population, not just the veterans population, H.R. 468 and H.R. 644 would provide a tax break, a credit in terms of 644, up to 30 percent of the cost incurred in actual credits, and I am a co-sponsor of those two bills, and I think that is a meaningful alternative to, and an incentive to, those people who might otherwise opt for nursing home care.

So, the Congress is beginning to recognize that there are alternatives, and it is taking some meaningful action. As a matter of fact, as part of the tax reform bill, it is my hope that this kind of venture will be attached to it, because I think it paves the way for future savings as well as providing for our elderly population.

I also noticed that you suggested that we ban the 96 hour rule for home visitations. I would appreciate it if you would elaborate on that for the committee because I would be interested in looking at that in terms of possible legislation in this area.

Dr. **Friedman**. I am sure that might have been confusing to some members of the audience also, but I do think that is a very critical issue.

Proprietary nursing homes and State veteran nursing homes are reimbursed on a per diem basis whatever the rate may be, one for the proprietary, on for the State veteran home.

If a member goes on an extended leave in excess of 96 hours, 97, 98, 150, the home is not reimbursed for the days he is gone, dating back to the first day. In other words, if he is gone for 150 hours from the home, the State gets—the proprietary homes or the State home gets no reimbursement whatsoever.

If, however, a member goes on a leave for 48 hours or 72 hours or 91 hours, it would be just for reimbursement purposes, just as if the veteran remains at the home. What it is doing then is a disincentive for an administrator to permit an individual to take a long term vacation.

I might suggest to you with our State veteran homes, we simply overlook it. We only get $17.05 from the VA and it is costing us $60, so the remainder of that—we will leave the $17.05 per day but will allow the individual back into the community.

But your proprietary nursing homes, as you already heard, it is very difficult for the VA to place them to start with because of the cost reimbursement. Factor in a long-term vacation, it is another disincentive to, as the gentleman to my right stated, the quality of life for the individual. We should delay to the last moment getting these—having these members placed in homes, but once they are, it should not be a closed door. We should get them out as much as we can.

Mr. **Smith**. Do you suggest a ceiling on the number of days to be permitted?

Dr. **Friedman**. I think I would leave that to you. The ceiling, of course, to the clinicians in the field would be whatever Congress——

Mr. Smith. In terms of the State homes that overlook the law, what is the average length of vacation or stay outside the home?

Dr. Friedman. Two weeks.

Mr. Smith. Two weeks. OK; I have a few more questions.

First of all, I want to commend the task force for its work and just say to you that Jim and I and others, members of this delegation, are working very hard on behalf of the clinic. We certainly are open to any idea, as Dr. Leone had suggested, of utilization of existing facilities rather than just construction of a new site.

The best pound for the buck, I think, is what we are looking for, and the better utilization and tying into local services, the better off the veteran will be in the long run.

So, I certainly would concur with that. We do need that kind of backing for our efforts also. I had four meetings downstate with the administrator, Harry Walters, on this very proposal, and my interest dates back to 1982, when we were looking at the possibility of such a facility in Mercer County, and when the need became apparent after the medic suggestion that Ocean County would be the priority area, all of our focus shifted to placing it in northern Ocean County for such a facility.

So, I want to thank you for that kind of support. It is crucial. In a phone conversation with Harry Walters about 2 weeks ago, he indicated to me that no decision had been made yet, but it is very—there is a great deal of interest being shown for the 1987 budget for such a facility. So, it is still very much of a hot item, and I think, with your support here and this committee, we stand a very good chance of securing it.

I do have one final question for Mr. Williams, and it really goes to the heart of why we need this facility, and that is the lack of utilization of either the Newark outpatient facility, which is too far, or of your VA facility in Philadelphia.

Do you have any kind of statistics on the utilization rates for Ocean County, Atlantic County, and Cape May County?

Mr. Williams. Yes, we do. I can get those for you. I will be glad to supply them to you. We keep it both for Philadelphia and East Orange, by county. So, we can probably get that information.

Mr. Smith. If you could, we would make that part of the record.

Mr. Williams. I will be glad and try and get that for you.

Mr. Smith. I appreciate that. Thank you.

Mr. Saxton. Thank you all very, very much. I think it is obvious that this is not only an important question, but a very interesting one that we could sit and talk about for a long time to come. Unfortunately, we are now 35 minutes behind schedule.

So, let me thank you again. It was very good testimony. It has been a big help to us. We certainly will be back in touch with you as time goes on, as we proceed with the reform of the system and projects related to it.

Thank you.

Is someone here from Congressman Howard's office? [No response.] I understood somebody was going to be here to give testimony. If not, we are going to proceed right along to Bart Fleming from HCFA.

Mr. Fleming is the associate administrator for the management and support services, Health Care Financing Administration, which we call HCFA. We thank him for coming to be with us this morning. I am sure that he has testimony that we will find very valuable. If you would like to proceed, we would appreciate it.

STATEMENT OF HON. BARTLETT S. FLEMING, ASSOCIATE ADMINISTRATOR FOR MANAGEMENT AND SUPPORT SERVICES, HEALTH CARE FINANCING ADMINISTRATION; ACCOMPANIED BY TOM BURKE, SPECIAL ASSISTANT TO THE HCFA ADMINISTRATOR

Mr. **Fleming**. Thank you very much.

Mr. Chairman, I am delighted to be here for several reasons. First of all, I spent 2 of the best years of my life in New Jersey, and probably 6 months of the most difficult. Now, the 2 years of—the best 2 years were when my wife and I were stationed at Fort Dix, NJ, as second lieutenant in the military police corps, and the most difficult was when I was stationed at Fort Dix, NJ, as a private in basic training. And, so, this is sort of a nostalgic trip for us because it is really our first trip back to this area. We have made many trips to the Toms River area and the beaches, but, more important, I am delighted to be here on behalf of the department and the Health Care Financing Administration.

I do not think there is any set of issues that are more important to this administration than the health issues and, specifically, the health care issues as they relate to our elderly citizens.

They are probably the most difficult set of issues politically. They—the focus of this administration has been high quality care, at the same time, bringing health care costs under control, and we are proud of the record. We have a long way to go yet, and I would like to talk just for a few minutes about that, if I might.

As you know, the Medicare Program was enacted in 1965 to provide insurance coverage of hospitals, physicians, and other medical services for the elderly. This coverage was extended to the disabled individuals in 1973. Now, almost 13 percent of the people in the United States or close to 31 million individuals, are covered by Medicare. This year, Medicare will pay medical bills for over 20 million beneficiaries.

Medicare was originally designed as primarily acute care benefit because hospital costs and follow-up services necessary after a hospital stay posed the most serious financial consequences to elderly individuals. However, the make-up of our country's population has evolved dramatically since Medicare first became law with significant implications for the present and future health care needs for the elderly.

A review of demographic trends indicates a significant potential for increased health services utilization by the elderly. Currently, there are about 28 million people over age 65, about 11 percent of our population. By the year 2030, the baby boom generation, will increase this proportion to 18 percent or about 56 million persons. In other words, by the year 2030, one in five persons will be elderly, twice the proportion today. In addition, the aging of the aged has significantly increased the demand for health care services, especially long-term care services, in the last decade, and will continue to do so well into the 21 century. For example, more than 20 percent of those over age 85 are in nursing homes, and those receiving home health care received 5 times more services than the younger elderly.

This decade, the portion of the population over age 74 will grow twice as fast as the general pcpulation in the younger elderly, and the younger elderly are between ages 65 to 74 and the older elderly are the aging elderly over age 74, 75 or older.

To assure that our senior citizens continue to receive the health care they need, we must, first, ensure that inflation in the health marketplace is contained to the point where it is no—where it no longer threatens the financial stability of Medicare, and other federally supported health programs. When this administration took office, Medicare was rising at 19 percent a year. In the past year, that growth has declined to 6 percent. I believe Congressman Tauke referred to the inflation of health care over the past several years, overall health inflation at 16 percent, Medicare was outstripping that by about 3 percentage points.

This has been——

Mr. SAXTON. Excuse me. Medicare costs are going up 19 percent a year?

Mr. FLEMING. Inflating at 19 percent a year for the overall medical costs of 16 percent.

This has been accomplished through reforms thet have resulted in an overall decrease in inflation throughout our economy, and through specific health care reforms designed to control costs while maintaining access to quality health care for our beneficiaries.

The single most important improvement in the Medicare Program since its enactment has been the implementation of the prospective payment system for hospitals, somewhat similar to the system that had been in operation here in New Jersey.

For over 17 years, hospitals were reimbursed on a reasonable cost basis, which failed to encourage efficiency, since we reimbursed basically whatever costs were incurred. Under prospective payments with the amount of payments set in advance and based on the patient's diagnosis, hospitals which organize and provide services in a highly efficient and cost effective manner, are rewarded. Over the long run, prospective payments should prove to be a valuable weapon in our battle to control the rise of health care costs while assuring adequate access and quality care to Medicare patients.

As we move into the second half of fiscal year 1985 and the second year of the phase in from a blend of regional and hospital specific rates to a fully national prospective rate, we can take pride in the smoothness of implementation to date. This success is a real tribute to the cooperation of hospitals, fiscal intermediaries, and other organizations which have worked so closely with this administration in its efforts. A total of 5,405 or 81 percent of all Medicare certified hospitals are now on prospective payment, and about 83 percent of all payments for in-patient hospital services in fiscal year 1985 have been made under the prospective payment system.

Changes in hospital behavior to adjust to the new system have been positive. Reductions in length of stay have moderated to the amount of resources needed to provide routine care. There is also evidence of a decrease in ancillary services, and the development of more cost-effective methods of providing services, including high technology procedures. Our monitoring of hospital behavior through peer review organizations indicates that beneficiaries are continuing to receive high quality care.

It was believed that the prospective payment system would encourage earlier discharges from hospitals, probably to other types of care, such as home health care. However, statistics from our monitoring of the system shows that discharges from hospitals to home health agencies have increased only slightly from 2.9 percent in January 1984 to 3.4 percent presently.

We believe that the Medicare prospective payment system has contributed significantly to the decline in the growth rate of Medicare Programs that I mentioned earlier and has prolonged the financial viability of the Medicare Program. However, current analyses indicate that by the beginning of the next century, the Medicare Program is going to again face a financial crisis. Clearly, alternate forms of health care delivery must be evaluated in terms of improving the cost-effective provisions of health care services to our increasingly elderly population.

An important innovation in providing health care to Medicare beneficiaries is the recent change in Medicare's relationship with prepaid health plans. Medicare can now contract with competitive medical plans, what we call CMP's, the acronym, and health maintenance organizations, HMOs, on a risk basis. We consider these contracts attractive for both beneficiaries and the Medicare Program. These plans offer our beneficiaries an alternative to the traditional fee for service cost reimbursement system. Beneficiaries will be free to choose between what we believe will be an increasing number of HMO's and CMP's. Incentives to join these organizations will be the additional benefit these plans choose to provide over the standard Medicare package. Most importantly, should Medicare beneficiaries, for whatever reason, become uncomfortable with their HMO or CMP, they have the right to disenroll immediately and rejoin the traditional fee for service Medicare system.

We also have several significant demonstrations underway to test some new delivery systems, and I understand that is one of the things that you are interested in talking about today. To improve our ability to target patients for whom expanded home health care services will truly substitute for institutional care. We are participating with the Department of Health and Human Services in the national channeling demonstration. The channeling demonstration is being conducted in 10 sites and is being designed to determine whether the long-term care needs of the elderly impaired persons can be met in a cost-effective way through a community based system of case assessment, care planning, and care management. The project combines innovative approaches to the organization and delivery of services, with broader service benefit packages.

The channeling demonstration has used a more precise targeting instrument, which has been able to identify a very frail elderly population. I must say, however, after the first 6 months, preliminary findings show that the number of patients from this group who enter institutions did not differ from that experienced by the control group, but this is early in that demonstration, and it is possible that as that demonstration matures and continues in time, that we may see some differences.

The demonstration is scheduled for completion in 1985, with a separate evaluation to be completed in 1986, and, of course, subsequent reports thereon.

The social health maintenance organization demonstration is now in the process of being implemented. The social HMO provides a broad range of acute and long-term care health and social services to voluntarily enroll the elderly persons for a fixed annual prepaid capitation amount. Four sites, in Minneapolis, Portland, OR, Long Beach, CA, and Brooklyn, NY, are now providing services. The social HMO demonstration will be conducted for 42 months and will be evaluated under a separate contract. We are also investigating alternative payment mechanisms to provide positive financial incentives for the more efficient operation of home health agencies.

Last year, we awarded a contract for the development of a prospective payment demonstration for home health agencies to test the effects of various prospective payment methodologies or expenditures, the quality of health care and the operation of home health agencies. We anticipate testing one or more of these methodologies in demonstrations beginning later on this year, actually July 1, I believe, they are scheduled to begin.

Finally, a contractor is working on the development of competitive bidding models for purchasing home health services. The competitive bidding models will be designed to use the marketplace to encourage the efficient delivery of home health services at the lowest available prices with no loss of quality.

The contractor will examine such issues as the use and scope of the bidding system, the danger of monopolistic effects, the units of reimbursement, and the bid and price selection methods. Late this year, we plan on selecting up to three methods designed by the contractor for further development and possible testing.

In conclusion, we recognize the critical need to assure the financial integrity of the Medicare Program. To do this, we must continue our efforts to assure appropriate utilization of health care services in the most cost-effective manner possible. Payment reforms and innovations in health services delivery certainly make significant contributions to controlling costs and we will continue to pursue additional mechanisms to improve our ability to reverse the escalation in health care costs which have jeopardized the retirement security of elderly Americans.

So, that concludes my statement. I would be happy to try to answer your questions.

Mr. SAXTON. Thank you. I appreciate that very much.

It seems to me that the concerns that we have and our constituents have, with regard to health care, can be broken down into two very general categories; one is the cost of it and the other is the level of care that you are able to receive.

There is a great deal of concern, for which you seem to allude to in your testimony, with regard to the level of or that, the type of care that is provided currently under the new DRG system, which certainly was put into place as a cost saver. There is at least a perception among beneficiaries of the Medicare Program that there is or may be some kind of a problem with regard to the length of stay in the hospital, and the type of services provided by the hospital or the doctor.

Is there a problem, in your view, with regard to that subject? And if you do see one, do you think that we need to do something to provide for a more flexible system?

Mr. FLEMING. Mr. Chairman, we do not detect any deterioration in the quality of health care. I really believe that the No. 1 concern of HCFA is that quality and access to care issue. We do not want to do anything that is going to disrupt that.

This country has a history of providing the very finest in medical care for its citizens. What we want to try to do is ensure that that continues for decades to come, so that we do not end up triaging, much like England has to do, where government sits as a judge of who gets treatment and who does not. It is very clear that we had to bring costs under control.

We do not detect any evidence that there is deterioration in the quality of health. Quite the contrary, we see some evidences that the prospective payment system has encouraged an increase in the quality of care.

I think you have to remember that when we talk about the quality of health care under the old system, we talked about such things as overutilization, the prescription of additional services, unneeded services, even operations that were unnecessary.

When we talk about quality of care, I think we have to talk about delivering exactly the care that is needed for the patient and the old incentives that were in place encouraged providers of health care to overutilize or overprescribe services.

We see that diminishing. Besides that, we also see providers of care, hospitals, beginning to specialize in services, which we know, from research demonstrations, does increase the quality of care and the favorable outcome.

Hospitals that have high degrees of—a high rate of delivery of a special service have much higher rates of outcome, positive rates of outcome in terms of discharge and mortality rates, much lower mortality rates, as a result of specializing and doing concentration of care, and we see that beginning to emerge.

Mr. SAXTON. Thank you. If there is anything that you can do to provide us with information relative to the exertion that, quality of health care may have actually increased under the system, we would appreciate it.

Mr. FLEMING. May I add one thing to that, Mr. Chairman, that accompanying the prospective payment system has been the introduction of the peer review organization or the PRO, roughly one per State, which are responsible for the medical review of the system, and their mission is quality of care as well as cost control.

Mr. TAUKE. Thank you, Mr. Fleming, for your testimony. I have to tell you that while some of the studies may indicate that the quality of care has improved, there is a lot of suggestion to the contrary in the second district of Iowa, and judging from the comments of my colleagues across the country, there is a lot of commentary in contrast to that throughout the Nation.

It is difficult to reach conclusions from anecdotal evidence, and I do not want to jump to a conclusion on the basis of reports that I hear in town meetings, in letters that are written to me and so on.

But, when the anecdotal evidence becomes fairly strong, it occurs to me that there is reason to believe there may be a problem. I do not see how the current system can present or, I should say, you can avoid having a problem under the current system because under the current system, all of the emphasis is on holding down the costs.

There is no incentive to the hospital to provide a better quality of care, at least that I see in the system, and I do not know how the PRO operates in New Jersey, but in Iowa, it is very clear that the major emphasis of the PRO is to keep the doctor from admitting people to the hospital.

There is no emphasis that I find or that my doctors find in encouraging them or the hospitals to provide quality of care. So, when I look at the system, and listen to what I hear from my constituents, it is difficult for me to conclude that there is any way that the system could be improving the quality of care.

Now, tell me why I am wrong.

Mr. **Fleming**. There is a lot in your statement and question. First of all, the system is designed to create incentives for the hospitals, for health care to deliver the quality of care, the kind of care that is needed at the time, that is needed.

We see that patients are being discharged to home health and to SNF, to skilled nursing facilities, and we see that patients are being returned to their own homes for home care earlier than they were, but we do not see any incident of increase in admissions.

Now, if this were true, if we were having wide-scale—wide-spread early discharges to the detriment of the patients, then accompanying that we would see readmission rates beginning to rise, because it would stand to reason that a sick patient released too early would have to be readmitted at some point.

But, we do not see that. The readmission rates are running way under 2 percent. Something like 1.7 percent, within 7 days.

Now, where we do get anecdotal evidence, we want to know that, because we can have and will have and do have our regional offices check that. We want to know the stories, the terror stories. We want to know the—along with the good testimonies of what has resulted from prospective payments, so we can check that out.

So, it also gives us an idea of where to look statistically. If we see a certain kind of practice anecdotally, beginning—then we can begin to look at the statistics of that.

Mr. **Tauke**. First of all, I agree that some changes had to be made, and let me emphasize that I think a lot of good has been accomplished, but where in the system is there any incentive for the hospitals or the doctors to improve quality of care?

Mr. **Fleming**. When I said your statement had a lot in it, that would be the other part.

I think the system encourages the providers of health care to compete. It requires them to compete, and I believe that it is in competition that we are going to see that quality increase. It is in the competition to attract patients, to bring physicians—to encourage physicians to refer to hospitals the quality of care that is going to go up.

I cannot imagine a hospital in a community providing a declining level of care, and as that begins—as that—as the story of that begins to penetrate the community, that that hospital being able to continue to attract patients or doctors are willing to refer to it. In fact, quite the opposite.

We have seen hospitals running marketing campaigns based on their record, based on their ability to provide increased and improved services.

Mr. **Tauke**. This is not the place to get into a debate, but let me say to you that I disagree very strongly with that statement.

First of all, the system attempts to establish monopolies, not competition in the community. If one hospital is offering a certain kind of service, the other hospitals cannot offer that service. We are attempting to avoid competition or duplication, as it is called under the law, through the certificate of need process in order to ensure that there is monopoly service.

So, we are down playing competition and, in a lot of communities, there is only one hospital, and even in communities where there are two hospitals, more and more, you see each hospital offering different services.

So, there is reduced competition. Now, the doctor has the patient come to him, and the doctor knows that if he puts the patient in the hospital, and the bureaucracy determines that he should not have, that he is in trouble. But, there is nothing that causes him to be in trouble if he should have put the patient in the hospital and does not, you know. Then, he does not run into any trouble with the bureaucracy.

The hospital knows that it is going to get a set amount of money for this kind of disease or whatever it is, procedure, that it is going to perform, and the hospital is not going to get any more money for doing a good job, it will not get any less money for doing a poor job, so the hospital is encouraged to cut corners in order to save money, knowing it is going to get the same reimbursement.

I think what I find puzzling about the system is that we are discouraging competition on the one hand, and, so, there is not that competitive—that competition that encourages quality, and, on the other hand, all of the incentives work against the quality of care, and in favor of holding down the costs, and we will talk about this, I am sure, often in the future, and this is not the time for a debate.

But, I guess I just think that that has to be analyzed very carefully by people in the Health Care Financing Administration and others as we attempt to figure out how to structure a system for the future.

Mr. **Fleming**. We are extremely concerned that that not perhaps be the reality of the prospective payments, and in that, we are in agreement. We do not want that kind of circumstance.

We do not believe, as we look at it, that that is the case. We do recognize that there is concern and because there is concern over that, we are watching very, very closely, and I know we will have conversations on it.

Mr. **Smith**. Thank you very much, Mr. Chairman.

Mr. Fleming, I am encouraged and I certainly construe by your statement that there is an increase in the quality of care. I know, in speaking to seniors in my district as well with physicians, they seem to indicate that that is their major fear, that there will be diminishment of the quality of care under the DRG system.

Tom Tauke mentioned a moment ago one of the barometers certainly are anecdotal stories. I have gotten a few of those via letters as well as conversations at town meetings. But, another one, it would seem to me, would be an increase in medical malpractice suits, and I was wondering if HCFA might have any statistics or whatever in terms of more medical malpractice suits being brought to bear.

Mr. **Fleming**. Specifically, HFCA does not direct its attention specifically toward malpractice, but it is something that we are aware of as an issue, an ancillary issue. So, it is——

Mr. **Smith**. It certainly would give us an indication whether or not the quality has diminished and, of course, those cases take time to work their way through the courts, but if we——

Mr. **Fleming**. If we have that, I will provide it for the record. Yes, sir.

Mr. **Smith**. I do have other questions. It has been reported at community based hospitals, especially small hospitals in rural areas, that are suffering under the DRG, rural hospitals report lower reimbursement rates as a result of the wage component of the prospective payment system.

HCFA, it is my understanding, is in the process of promulgating regulations as part of the Deficit Reduction Act. Can you tell us, has that been done yet?

Mr. **Fleming**. The NPR, in notice of proposed rulemaking, is out. We are in the comment period, and the comment pericd closes in July, and then we would be coming out with a reg at the end of the summer.

We are aware of the concerns of the rural hospitals. We are equally concerned about that. We do not believe that the regulation is going to generally penalize as a group rural hospitals.

Mr. **Smith**. One other question. We all know that under part A of Medicare Part A, after a certain amount of stay within a hospital, the patient is required to provide a copayment. It is my understanding that at this point, home health care does not have a copayment. I was wondering if HCFA or the administration have any plans of proposing that a copayment be provided.

Mr. **Fleming**. Yes. There is a small copayment, which is the equivalent to 1 percent of the hospital deductible, of the inpatient deductible. It would amount, based on the average number of home health visits, to about $4 per visit, which comes out to about $20 per year.

Mr. **Smith**. OK. Thank you. Yield back the balance.

Mr. **Saxton**. Mr. Fleming, thank you, and, like the last panel, we could have a lengthy conversation on this subject. Unfortunately, we do not have time this morning, but I do appreciate very, very much your traveling here to be with us this morning, this afternoon, I guess, by now, and your testimony—still morning, I am told. OK.

And, but, we do appreciate it. It has been very, very helpful, and we certainly will look forward to seeing you again in the future and talking about this subject.

Mr. **Fleming**. Chairman Saxton, thank you very much. It has been my pleasure, gentlemen.

Mr. **Saxton**. We are going to move right along. We are running slightly behind.

Our next panel is on home health care as an alternative. John Paul Marosy, executive director of the Home Health Assembly of New Jersey; Charles Kauffman, administrator, Ocean County Health Department; Patricia Hines, deputy director, Ocean County Board of Social Services; Sister Theresa Congroy, public health nurse, Ocean County. Also testifying on this panel is the past president of the New Jersey Medical Society, Dr. Alfred Alessi, and we are going to hear from Dr. Alessi first.

Let me say that, unfortunately, our time schednle has been pretty much shot, and we are quite far behind. And, while we do not like to do this, I am afraid we are going to have to limit testimony to 5 minutes or we will not do all of the things that we hoped to do today. There are a number of people who have come to testify, so that in order to make time for everyone, somebody is going to let me know at 4 minutes and I will let you know that you have 1 minute to summarize so that we can get through the initial testimony and go right into the questions and answers.

Doctor.

STATEMENT OF DR. ALFRED ALESSI, PAST PRESIDENT, NEW JERSEY MEDICAL SOCIETY, HACKENSACK, NJ

Dr. **Alessi**. Congressman Saxton and other Members of Congress, I want to thank you for the privilege of being able to discuss health care cost issues for the elderly. This is an explosive and a very complex issue, and I am sure it concerns everyone of us.

Health care costs will be controlled, but my question is, what is the price of controlling the cost. I wonder how many of you personally know someone that has had coronary bypass surgery, someone that has had a premature infant that has been saved, someone who has been saved from cancer. I am sure that probably everyone of you will answer in the affirmative. They have been cured.

I would point out to you that in 1950, these diseases were not being cured uniformly, and, at the present time, these diseases are being cured. All of these were failures of the past, but now we have survivors. Now, they quote to you that the gross national product has increased from 4.5 percent in the fifties to 10.5 percent at the present time. That is a lot of money.

But, is it too much? I want to ask you, can you put a price on the health of your family? Can you put a price on the care that your individual children are getting?

Now, at the present time, Government sets a price for any disease that occurs, and the elderly, of course, are prone to diseases, and they have the high volume that occurs.

Now, in the use of this system, we switch responsibility for the elderly. The elderly now cannot be left in the hospital as long as we as physicians feel that they should be left in the hospital, and we have to discharge them. And, the problem that we are up against is the health care facility for the elderly, after discharge from the hospital, is not adequate. They are certainly not adequate in our State at the present time.

So that this is an issue that has to be resolved under the present PRO and DRG systems.

Now, we have problems in the future. Transplant surgery is now here. Who will get the transplant surgery? It is costly, and society and Congress and society in general is going to have to decide these issues.

At the present time, and I have been involved in the practice of surgery in this State for 40 years, I have also been involved in the DRG system since its inception; as yet know, the DRG system was started in New Jersey.

Now, at the present time, there is 10 to 15 percent of the hospitals in New Jersey, at the present time, that are failing, and there is a threat that from 10 to 15 hospitals in New Jersey will have to fold up at the end of this year. When hospitals fail to balance their budgets, health care is certainly underlined.

The administrators look at any new and innovative procedures that are suggested to them. They want to know where the money is coming from, they want to know is it a type of treatment that is going to save money for the hospital, or is going to make money for the hospital. It is not being decided on the thing of quality of care and that medicine has to progress.

Mr. **Saxton**. Doctor, you are at the 4-minute mark.

Dr. **Alessi**. All right. Physicians at the present time are advocates for quality of care. We can tell you that it is our impression that the quality of care is being impaired in the State of New Jersey at the present time.

We cannot admit people to the hospital unless we meet certain PRO criteria. We are being pressured to discharge people early. We are concerned about long-term care facilities being adequate. We are concerned about money being available for capitation in the hospitals. There is not enough under the system.

Senator Durenberger has acknowledged this. There is not enough money in the system for medical education and there is not enough money in the system for new and innovative procedures.

I think you have to realize that physicians under the firing line are the only advocates at the present time for quality of care, rather than just cost.

Mr. **Saxton**. I understand you have to leave.

Dr. **Alessi**. I can stay a little while longer.

Mr. **Saxton**. All right. My two colleagues and I were interested in asking almost identical questions of the last witness, and it had to do with this same subject.

He asserted that the quality of care has increased or has gotten better under the DRG system, and you just told us that it did not.

Other than the information that you have given us, do you have anything concrete that you can point to that we can take back to Washington to say here is what happened in this study or here is what happened in these specific cases?

We need something, as Congressman Tauke pointed out. We are at town meetings. We talk to people on the street. We go to senior citizen meetings. In New Jersey, when I talk to people generally about health care, I hear negative comments in terms of the quality of care that is currently being provided, as we just heard from you.

I have yet to see any kind of documentation.

Dr. **Alessi**. Congressman, we physicians are practicing. We do not have time to accumulate statistics. It is a very complex issue. We do not have the money. We do not have the facilities to computerize statistics to give you.

All I can report to you is that I have traveled all over the Nation talking on the DRG program. I have traveled all over the State of New Jersey——

Mr. **Saxton**. Excuse me. I understand that, and I hear the same things that you are telling me. I am trying to be helpful.

The New Jersey Medical Society, when I was in the State legislature, provided us with reams of informatian on various stands and proposals that they took, and I am waiting for that type of information on this subject.

Dr. **Alessi**. Well, we have accumulated material, but in the limits of 5 minutes of time, I cannot present it to you, but we will see that your committee gets some concrete examples of what we are talking about.

Mr. **Saxton**. That would be helpful and appreciated. I am sorry to have had to limit your time, but in the interests of this whole hearing, I guess that is what we will have to do.

Tom, do you have anything?

Mr. **Tauke**. You heard my comments earlier, so I will not reiterate those. But, you raised another issue, which I think is critically important for us to address, and that is this question of what percent of our wealth should we devote to health care, and I just—I get very skittish about Government deciding that question.

For some people, the best quality of health care available is what they want, regardless of the cost and they will put 50 percent of their resources into it, if necessary. Others really do not care that much. I just, in my last 2 years, went through an experience where both my mother and her brother died of cancer.

My mother wanted the best treatment. She wanted to give it every shot, you know, whatever it took, whatever pain had to be endured, she was willing to go through it because she wanted to take the chance.

My uncle was just the opposite. He said, you know, it is my time to die and just leave me alone, and he did not want to put all his money into health care.

But, under the DRG system, every patient gets put into a slot, you know, and I just am bothered by that, and I would think the physicians would have a very difficult time trying to plug everybody into a slot, every patient into one of 435 slots or however many there are.

Dr. **Alessi**. Yes. Patients with the same disease vary. No two patients are alike. Different patients consume different resources, and their requirements are different.

But, I have never had a patient come to me and say they want less. They want everything possibly done for their loved ones, and that is the problem with the system at the present time. Patients are being put in slots, and we, as physicians, feel that individual patients require different things, and we do not have the leeway to do this at the present time.

Mr. TAUKE. Thank you, sir.

Mr. SMITH. Dr. Alessi, you heard my question before to Mr. Fleming regarding the potential increase in medical malpractice.

Have you seen, among your colleagues, any increase in the incidence of malpractice suits?

Dr. ALESSI. Yes. You bring up a very important issue. There has been an increase in professional liability in the State of New Jersey, and we can document this statistically.

When patients are put in an antagonistic attitude with their physicians, we try to—we are pressured to discharge a patient early. Something happens, the physician is the one that is held responsible. There has been an increase in professional liability in the State of New Jersey.

At the present time, the obstetricians, for instance, have a professional liability insurance of $63,000. Neurosurgeons have something like $78,000 to $80,000. We are not seeing some of these new specialties coming into the State because of the increase for professional liability insurance.

Mr. SMITH. In a similar vein or parallel then, would you be supporting some of the congressional efforts to cap in some way the amount that a person could be awarded?

Dr. ALESSI. Yes. I think caps are an absolute necessity among other things that will have to be done. New York State, for instance, and I have met with the New York State people, they cannot get a neurosurgeon to go into New York State where the professional liability is a $193,000 a year.

Mr. SMITH. One final question, and I know you are pressed for time.

You indicated a moment ago that between 10 to 15 percent of the hospitals in New Jersey are in the process of failing. Are those rural hospitals or inner-city hospitals, and do you forsee any changes in the regulations that HCFA will soon promulgate that could ameliorate that problem?

Dr. ALESSI. Yes. The statistics that I gave you were obtained by our executive director from the Commissioner of Health's office. I do not have the breakdown of what type of hospitals it is, but, I think, at anytime, we have only 94 hospitals in the State of New Jersey, when we have 10 to 15 percent of the hospitals in financial jeopardy, I think that is a serious problem.

Mr. SMITH. OK. Thank you. And, if that could be provided for the record, we would certainly appreciate it.

Dr. ALESSI. Sure. Thank you.

Mr. SAXTON. OK. Doctor, all of our time has expired and we thank you very, very much for your testimony, and, as I would like to reiterate to you, anything that you can provide for us for the record relative to the position we should take on the level of care provided would be greatly appreciated.

Dr. ALESSI. Thank you for excusing me, Congressman.

Mr. SAXTON. OK. Can we proceed from whichever—from right to left, I guess.

STATEMENT OF JOHN PAUL MAROSY, EXECUTIVE DIRECTOR, HOME HEALTH AGENCY ASSEMBLY OF NEW JERSEY, INC., PRINCETON, NJ

Mr. MARCOSY. Thank you, Congressman Saxton, Congressman Smith, Congressman Tauke, for the opportunity to present information here today. I am John Paul Marosy, the executive director of the Home Health Assembly of New Jersey. We present over 100 home health care providers and allied professionals from every part of the State.

In 1983, our agency served 133,000 New Jerseyites of all ages. Persons over 65 years of age represented two-thirds of the total number of home health patients served, and persons over 75 years of age received over half of all home nursing visits in New Jersey.

Mr. Chairman, there is a quiet crisis brewing behind the closed doors of homes of thousands of older New Jerseyites. The policies of the Federal health care financing administration are pushing an increasing number of frail, older people and their families into a no-care zone. This crisis has been quiet so far because those who are feeling the pain are those least capable of complaining. The low- and moderate-income older people. Most of them over 75 years old, who suffer from chronic diseases. They and their family members cannot get the home health care help they need unless they are willing to impoverish themselves and become eligible for Medicaid.

Even then, they face bureaucratic hurdles which many of them just cannot overcome. The frequent result is inappropriate placement in a nursing home where the older person is separated from family and robbed of human dignity.

Ironically, the quiet crisis is hitting families in New Jersey, where we have been most successful in reducing the cost of hospital care. We have reduced the length of stay in New Jersey, quicker and to a greater degree than in other States around the country.

We have conducted two reports and I have attached the results of those reports to my testimony, which points out three major facts.

1. Home health care agencies in New Jersey have the capability of caring for sicker people at home. High-technology care, weekend care, evening care has expanded in the last 3 years.
2. New Jersey's prospective payment system for hospital care, which is based on DRG's, is resulting in shorter hospital stays. The average has dropped from 7.4 to 6.3 days.
3. The Federal health care financing administration is pursuing policies which are strangling the home health agencies in redtape, and increasing administrative costs while they are restricting reimbursement for Medicare home health benefits to the point where older Americans cannot obtain the health care that Congress has intended for them to receive.

Seventy-two percent of the home health agencies responding to a survey this spring reported an increase in the number of cases where reimbursement was denied by Medicare for home health care.

The rate of increase in such denials exceeded over 100 percent, in some cases. HCFA has dramatically increased the amount of written documentation necessary from agencies for each claim submitted and has tightly restricted the types of cases where it will pay for home health care.

Home health agencies have had to add clerical staff, buy copy machines, and require nursing supervisors to take time away from their nursing supervision and fill out more paper work.

Our survey showed that these items added an average of $27,000 in administrative costs to each agency which reported such added costs. So, who is being denied care? We have examples from throughout the State.

I would like to cite one. A 79-year-old widow, retired school teacher, who lived with her three elderly sisters in Patterson, was one victim thrown into the no-care zone. The three sisters are over 70 years old and were coping as best they could with their needs. She was diagnosed as having cancer of the left orbit, the socket of the eye, with wide incision lesions of the face and neck.

She received service for 3 months before being hospitalized to have her right eye removed, secondary to widespread infection behind the eye. She requires daily nursing care at home after discharge. This care involved irrigation, dressing changes, treatment of facial tumors, which easily bled, monitoring of vital signs, pain control, and bowel control.

She was weakening, she was bedbound and immobile. The visiting nurse agency involved provided the care, 7 days a week, from September through November 1984. The patient died in November.

In March 1985, the visiting nurse agency received notification that the nursing visits provided in excess of five times per week were retroactively denied as of October 1, 1984. The agency could then either bill the sisters, who all lived on limited incomes, seek charity payments, or somehow absorb the cost of care.

The numbers of these cases are increasing. I have brought another tragic example from Mercer County and one from Camden County. My colleagues here in Ocean County have seen the same kind of cases. The problem is we are discharging people earlier from hospitals.

Home health agencies can serve people in most cases, but Medicare's reimbursement policy for home health care has not changed with the conditions of people being discharged from hospitals.

Finally, we have several suggestions for actions that the Select Committee on Aging can take.

Mr. SAXTON. Excuse me. Can you summarize them? A, B, C.

Mr. MAROSY. OK.

1. We suggest that the committee hold a congressional hearing to investigate how the home health care benefits under Medicare is being administered.

2. We support enactment of Federal legislation to expand the Medicare home health benefits to include long-term care. Senator Bradley's bill, S. 788, is a good example.

3. In the Veterans' Administration, in 1983, the Veterans' Administration discontinued paying for home health aide visits for veterans. We feel that that should be reinstated so that veterans

are at least eligible for what the rest of the older population is eligible for under Medicare.

Thank you very much for your attention.

[The prepared statement of Mr. Marosy follows:]

PREPARED STATEMENT OF JOHN PAUL MAROSY, EXECUTIVE DIRECTOR, HOME HEALTH AGENCY ASSEMBLY OF NEW JERSEY, INC., TOMS RIVER, NJ

Members of the Select Committee on Aging, ladies and gentlemen, I am John Paul Marosy, Executive Director of the Home Health Agency Assembly of New Jersey, Inc., an organization which represents over one hundred home health care providers and allied professionals in the State of New Jersey. The Home Health Agency Assembly was founded eleven years ago and is the leading voice of the home health care industry in the State of New Jersey. We are proud of the high quality of care that home health agencies provide for New Jerseyites, and we appreciate this opportunity to share our insights with the Committee. In 1983, certified home health agencies served 133,000 New Jerseyites of all ages. Persons over 65 years of age represented over two-thirds of the total number of home health patients served, and persons over 75 years of age received over half of all home nursing visits.

NO-CARE ZONE

Mr. Chairman, there is a quite crisis brewing behind the closed doors of the homes of thousands of older New Jerseyites. The policies of the federal Health Care financing Administration are pushing an increasing number of frail older people, into a No-Care Zone. This crisis has been quiet, so far, because those who are feeling the pain are those least capable of complaining: low and moderate income older people, most of them over seventy-five years old, who suffer from chronic diseases. They are their family members cannot get the home health care help they need unless they are willing to impoverish themselves. Even then, they face a series of bureaucratic hurdles that many cannot overcome. The frequent result is inappropriate placement in a nursing home, where the older person is separated from family and robbed of human dignity.

Ironically, this quiet crisis is hitting families in New Jersey with extra harshness precisely because our efforts to control the cost of hospital care are succeeding so well. We have conducted two studies (which I have attached to this testimony) which detail the reasons for so many families falling into the No-Care Zone. Three facts emerge which deserve the attention of the Congress and of New Jersey State Government:

First: Home health care agencies have the capability of caring for sicker patients at home. Over the past three years, many agencies have added weekend and evening coverage, and over two-thirds of the agencies in New Jersey now offer types of high technology care that, just a few years ago, could be offered only in a hospital setting.

Second: New Jersey's prospective payment system for hospital care, which is based on Diagnostically Related Groups (DRG's), is resulting in shorter hospital stays for older patients. Since New Jersey began its DRG system in 1980, the average length of stay has dropped from 7.43 days to 6.39 days.

Third: The federal Health Care Financing Administration is pursuing policies which are strangling home health care agencies is red tape, increasing administrative costs, and restricting reimbursement for Medicare home health benefits to the point where older Americans cannot obtain the help that Congress has intended for them to receive.

"RED" TAPE COST: $27,000 PER AGENCY

Seventy-two percent of the home health agencies responding to a survey conducted by the Home Health Agency Assembly this Spring reported an increase in denials over the past six months. The rate of increase exceeded over 100% in some cases. The Health Care Financing Administration has dramatically increased the amount of written documentation necessary from agencies for each claim submitted and has tightly restricted the types of cases where it will pay for home health care. Home Health agencies have had to add clerical staff, buy copy machines and require nursing supervisors to spend more time doing paperwork to meet documentation requirements. The survey showed that these items added an average of $27,000 in administrative costs to each agency which reported such added costs.

Who is being denied care? A 79 year old widowed, retired school teacher who lived with her three elderly sisters in Patterson was one victim thrown into the No Care Zone. The three sisters are over seventy years old and were coping as best they could with her needs. She was diagnosed as having cancer of the left orbit with wide excision lesions of the face and neck. She received service for three months before being hospitalized to have her right eye removed, secondary to widespread infection behind the eye. She required daily nursing care at home after discharge. This care involved irrigations, dressing changes, treatment of facial tumors (which easily bled), monitoring of vital signs, pain control, bowel control. She was weakening, bedbound and immobile. The visiting nurse agency involved provided the care, seven days a week, from September through November, 1984. The patient died in November. In March 1985, the visiting nurse agency received notification that the nursing visits provided in excess of five times per week were retroactively denied as of October 1, 1984. The agency could then either bill the sisters (who all live on limited incomes), seek charity payments or, somehow, absorb the cost of care. I brought another tragic case example from Trenton with me and have attached it herewith.

As the number of persons over 65 continues to climb, these policies of the Health Care Financing Administration are transforming the already difficult job of the visiting nurse into an impossible task.

ACTION NEEDED NOW

The crisis in family care of the aged should not be "quiet" for much longer. We in the home health care industry urge the Select Committee on Aging to continue your efforts to bring this crisis to public attention. We would support the following actions:

1. A full scale congressional hearing should be held to investigate the action of the Health Care Financing Administration (HCFA) in its management of the home health care benefit under Medicare. Specifically, HCFA should be required to justify the recent tightening of eligibility of the home health benefit and to explain the reasoning behind its burdensome paperwork requirements;
2. Enactment of federal legislation to expand Medicare home health care benefits to include long term home care for those with chronic illnesses. Senate bill # S.788, the Senior Citizen Independent Community Care Act, submitted by Senator Bill Bradley, would achieve this purpose.
3. Whoever wins the election for Governor of the State of New Jersey this November should address the crisis in family care of the aged as a top priority. The Home Health Agency Assembly of New Jersey has developed a concept paper which outlines a cost effective plan for cooperation between state government and local private groups to assist families in their labor of love.

The No-Care Zone is growing.

The time to stop its growth is now.

REFERENCES

1. Marosy, J.P., Testimony Before the Forum on Alternative Reimbursement Systems, for Home Care." National Association for Home Care, Washington, DC, 1985.
2. "Summary of Claims Denial and Waiver of Liability Survey," Home Health Agency Assembly of New Jersey, Princeton, NJ. 1985.
3. "1983 Home Health Data—Home Health Agencies in New Jersey," Home Health Agency Assembly of New Jersey, Princeton, NJ, 1985.

ATTACHMENTS

Case Example #1—Paterson, NJ, Passaic Valley Hospice.
Case Example #2—Trenton, NJ, Visiting Nurse Association of Trenton.
Case Example #3—Camden County, NJ CHANS.

CASE EXAMPLE NO. 1, PASSAIC VALLEY HOSPICE, WAYNE, NJ

Seventy nine year old widowed, retired school teacher living with 3 elderly sisters (all over 70 years old)

Diagnosis: Cancer of the right orbit with wide excision lesions of face and neck

Patient was on service June 26, 1984 through August 27, 1984 when she was hospitalized to have the right eye removed secondary to widespread infection behind the eye.

Patient readmitted on September 11, 1984 and died November 17, 1984.

During this time, the patient required daily irrigations and dressings to the right orbit and facial area secondary to copious odorous drainage, pain and rapid tumor spread. The 3 sisters were unble to do this dressing and there were no available friends or relatives willing to do same. There was one occasion that required an additional nursing visit when the patient had an episode of bleeding that was difficult to stop. The patient had extensive rapidly growing facial tumors that also required care and treatment on a daily basis. As patient deteriorated, a home health aide was placed for bathing, dressing, positioning, and feeding. The sisters assisted and provided as much care as they could but were unable to provide all care the patient required. Nursing care involved irrigations, dressing changes, treatment of facial tumors (which easily bled), monitoring of disease progression, vital signs control, bowel control, ongoing instruction and demonstration of care for a gradually, weakening bed bound, immobile patient, and later, catheter insertion and instruction of care.

On March 18, 1985, we were notified that nursing visits over five times per week were denied as of October 1, 1984.

CASE EXAMPLE NO. 2A AND NO. 2B, TRENTON VISITING NURSE ASSOCIATION

No. 2A is an 82 year old client who developed a tumor on the spinal column. The tumor was removed, but she is now partially paralyzed. She therefore spends a great deal of time in a wheelchair. She was referred to the agency for skilled nursing care to dress a large open wound on her lower back. Because of the depth of the wound, and the amount of drainage, our nursing staff visited two times per day to attend to, clean, and dress it. She also has the assistance of a home health aide two times per week. The wound has now improved to a point where dressings can be changed one time per day. However, because daily care is not "Intermittent", even the once daily treatments will not be covered by Prudential for very much longer. The intermediary assumes that family, friends, or neighbors can learn such care thus decreasing the client's dependence on paid nursing service. However, Mrs. lives alone and does not have family in the area, or friends who can do the care. Thus, she may need to go into a nursing home simply because her Medicare benefits do not cover her care at home. This woman is independent and proud of her ability to remain at home in spite of her physical limitations. To remove her from her home and community because her care does not fit arbitrary requirements is indeed tragic.

No. 2B [deleted] is an 81 year old paraplegic with a neurogenic bladder and decubitus ulcers. She was referred to the VNA in January of 1984 for care of a large decubitus ulcer and care of a foley catheter. Since then she has been hospitalized two times for skin grafts to her sacral decubitus ulcers. Her last skin surgery was in March of this year.

[Deleted] is dependent on a home health aide and a visiting nurse to provide personal care, skin care and foley catheter care. She gets out of bed only when help is available and with the use of a hoyer lift. Daily skin care is essential to prevent the need for further skin surgery and hospitalization. Under Medicare, she receives a home health aide only three times a week. [Deleted] husband expired in April of 1985 and since then she has lived alone. Her family assists her on weekends but work full time and are limited on what they can do during the week. She is financially unable to hire additional services and does not qualify for Medicaid.

CASE EXAMPLE NO. 3—CAMDEN COUNTY COMMUNITY HEALTH AND NURSING SERVICES OF GREATER CAMDEN COUNTY, INC. (CHANS)

The following patient demonstrates that, while a community may have in place other supportive services to supposedly take care of patients after their Medicare benefits run out, there really is a gap in the service "net".

Mr. D.B., age 77, resides in Camden County. His wife, recently deceased, was 70 last year. The Community Health and Nursing Services of Greater Camden County, Inc. served Mr. D.B. seven months last year. He has cancer of the prostate, which has spread to his bones and lung; he has angina and coronary insufficiency; and he has multiple sclerosis. He is wheelchair bound at home. From February to September, Mr. D.B. received numerous intermittent nursing visits to monitor pain and his cardiac problems, as well as physiotherapy to give hime some degree of ambulatory prowess, if possible. Medicare covered these visits. His wife had cancer and was debilitated and could not care for her husband; so the agency also sent in an aide two hours a day three days a week. The wife's cancer was not considered acute; and she received no Medicare help for herself at that time.

Mr. D.B.'s condition "plateaued" by Medicare standards of rehabilitation by September. The Medicare visits were terminated, but he still needed personal care. The agency first was able to utilize the Senior Citizens United Community Services "homemaker" service; but that program only gives care for a one month period. Meanwhile, the agency applied for care for Mr. D.B. from the Demonstration Project for the frail elderly at risk population under the Camden County Board of Social Services. This program selects recipients on a random basis, through a computer, not based on need; and Mr. D.B. was not lucky. He was not selected for care. Finally, the agency applied for care for him under Title XX. But there is such a demand for this service in Camden County, that he can only receive a homemaker one day a week.

The agency is concerned about Mr. D.B. He obviously needs more personal care than one day a week. But there is no program in place to help him. When the nurse explains to him that there is no care available under current standards to meet his needs, the patient is totally demoralized. He hates himself for growing old. His only option is to pay privately, to use up all his resources until he is pauperized and becomes Medicaid eligible.

SUMMARY OF CLAIMS DENIALS AND WAIVER OF LIABILITY SURVEY

Completed surveys were received from 36 home health agencies, representing all agency auspices—13 public, 14 free-standing, 7 hospital-based, 1 proprietary, and 1 combined public/free-standing. Agency size, as measured by volume of Medicare visits, was representative of agency distribution statewide. Of the 36 responding agencies, 32 used Prudential as their fiscal intermediary, 2 used Blue Cross of New Jersey, one used Blue Cross of Michigan, and one no answer.

MAGNITUDE OF PROBLEM

It is apparent form the survey responses that home health agencies in New Jersey have experienced an unusual and alarming increase in loss of waiver of liability and claims denials in the past year (since January, 1984). Fourteen agencies (39%) reported loss of waiver of liability. Moreover, 26 (72%) report an increase in denials over the past six months, as compared to the same period, one year ago. The rate of increase in claim denials varied from under 10% to over 100%.

DENIAL AREAS

Most agencies who experienced an increase in denials were able to identify particular service plans for which more denials were found than others. Home health aide, physical therapy, daily nursing and medical social work were the most frequently reported denial services.

Sixteen agencies cited denials for home health aide service in excess of 3 days/2 hrs per week. Fourteen agencies experienced denials for PT (and other therapies), usually in expended rehabilitation situations. Daily nursing, especially for wound care requiring daily dressing change, was identified by 10 agencies. Social work denials were reported by 9 agencies. Denials for aide and nursing services deemed 'maintenance' as opposed to 'skilled' was described by three agencies. Other reported denials included visits for Vitamin B 12 injections, denials on 'homebound' status, and denials for nursing visits close to discharge.

ADDED COSTS

While the costs associated with denials and waiver of liability are insidious and difficult to quantify, a significant number of agencies were able to identify specific cost increases directly related to these activities.

ADDITIONAL STAFF

Nineteen agencies reported the hiring of 8.3 FTE nurses and 12.4 clerical staff specifically to deal with increased record review, documentation, and reporting activities resulting from denials. A total cost of $330,240-$177,075, nursing; $153,149, clerical—was incurred by the 19 agencies, or an average of $17,381.05 per agency.

OVERTIME

Twelve agencies stated that they definitely had incurred overtime expenses in satisfying the documentation requests of their fiscal intermediary. The average overtime cost of the agencies who had broken out this expense was $7,000.

COPYING EQUIPMENT AND SUPPLIES

In most cases, copying and materials expenses refer to the per unit increases brought about by the additional documentation requirements. However, five agencies reported that the extra demand overloaded their copier capacity and they had to purchase a new copier. Nineteen agencies identified either per unit, supplies, or equipment costs directly related to increased regulations for documentation. Total reported costs were $61,327 or an average of $3,227.74 per agency.

Based on these reported costs, the average agency incurred expenses of $27,608.79 in responding to fiscal intermediary claim denials.

Additional staff, $17,381.05; Overtime, $7,000; Copying/materials, $3,227.74; total, $27,608.79.

OTHER COSTS

Many survey responders pointed out that the most important cost of excessive documentation is calculated not in dollars and cents but in quality of care. Excessive documentation requirements reduce the time available for patient visits and staff supervision which are the guarantees of quality service. Likewise, the time and energy of administrators is distracted from creative activities by paperwork demands, to the ultimate detriment of the home care patient.

EXECUTIVE SUMMARY—1983 HOME HEALTH DATA

This report presents comprehensive data describing the certified home health agencies in New Jersey in 1983. Home health data from the four year period between 1980 and 1983 are also reviewed for trends in agency characteristics and service. The data reflect a growing and expanding industry.

GROWTH IN HOME HEALTH ADMISSION

Admissions to home health agencies increased from 90,000 in 1980 to 133,000 in 1983—a growth of 48% over the four year period.

GROWTH IN AGENCY AUSPICE FOLLOWS NATIONAL TRENDS

Between 1980 and 1984 in New Jersey, one municipal home health agency was closed and five new home health agencies were certified. Of the five new agencies, one is a hospital-based agency, one is a not-for-profit community agency, and three are proprietary (for-profit) agencies. The total number of agencies increased from 47 to 52—an eleven percent increase over the five year period. The distribution of new agency types is consistent with national trends, which show an increase of agencies in the proprietary sector and a decline in government sponsored agencies, with hospital-based and voluntary community agencies maintaining their market share.

EXPANSION OF HOURS OF OPERATION

The trend to expanded hours of operation—both business hours and service hours—is the most striking change in agency operations in recent years. Most agencies (82%) schedule admissions and visits seven days per week, and virtually all agencies provide emergency phone and referral service around the clock. Four years ago, only 66% of the agencies offered evening and weekend coverage.

CLIENT REFERRAL SOURCES

Hospitals are the major source of referrals to home care, representing 67% of all referrals. Between 1980 and 1981, the percentage of referrals from hospitals increased from 61% to 69%. However, since 1981, hospital referrals, as a percentage of all referrals, have remained constant.

AGE DISTRIBUTION

The elderly are the most frequent users of home health care. Persons over 65 make up 68% of all nursing patients and 78% of all nursing visits. As the population ages, the demand for home health care will increase proportionally. Based on current use rates and population projections for the year 2000, we can estimate a 27% increase in home health clients by the end of the century—a growth rate of approximately one and half percent per year.

PAYMENT SOURCES

Home health services are paid for predominantly by Medicare and Medicaid. Medicare is the source of payment for 63% of nursing patients and 72% of nursing visits.

CHARGES PER VISIT

In 1983, the average charges for professional visits ranged from $42 to $48. Home health aide charges were $11.12 per hour or $32.29 for a 2.9 hour visit. The differences between high and low charges among the agencies are significant. Differences among different geographic sections of the state are minimal.

AVERAGE COST PER CASE

An average home health client receives a combination of nineteen nursing, therapy, and/or home health aide visits over his/her period of service. The average cost per case is approximately $690.

Copies of the full report, "1983 Home Health Data—Home Health Agencies In New Jersey" by Marietta Taylor, are available at $10.00 per copy from the Home Health Agency Assembly of New Jersey, Inc., Center for Health Affairs, CN-1, 760 Alexander Road, Princeton, NJ 08540. 609-452-8855

PREPARED STATEMENT OF JOHN PAUL MAROSY, EXECUTIVE DIRECTOR, HOME HEALTH AGENCY ASSEMBLY OF NEW JERSEY, INC.

Senator Moss, distinguished members of the panel, ladies and gentlemen: I am John Paul Marosy, Executive Director of the Home Health Agency Assembly of New Jersey, Inc., an organization which represents 51 of the 54 certified home health agencies in the state of New Jersey. The Home Health Agency Assembly was founded eleven years ago and is the leading voice of the home health care industry in the state of New Jersey. We are proud of the high quality of care that home health agencies provide for New Jerseyans. In addition, we are proud of the leadership that our Governor, Tom Kean, and the members of New Jersey's Congressional delegation, in particular Senator Bill Bradley, have displayed in seeking to assure access to home health care for the millions of Americans who need this help to remain in the dignity and comfort of their own homes.

In 1980, New Jersey became the first state in the nation to implement a prospective pricing system for hospital care, based on diagnostically related groups (DRG's). We have closely monitored the impact of this method of paying for hospital care on the home health care industry in New Jersey.

A data report by our organization that was just published documents three important facts:

1. The DRG system in New Jersey has increased the number of hospital referrals to home health care.
2. Home heath agencies have greatly increased their provision of high technology care in the home in order to respond to the earlier discharges, and
3. Home health agencies have expanded their hours of operation to meet hospital discharge requirements.

In the remainder of my testimony, I will describe New Jersey's DRG system, report our data findings, and point out what we see as contradictions in current health care policy which are preventing home health agencies from providing care to those in need.

NEW JERSEY'S SYSTEM OF PROSPECTIVE PRICING FOR HOSPITAL CARE

In 1980 New Jersey established a system of prospective payment for hospital care, based on DRG's, under a federal Medicare waiver contract. The Department of Health and Human Services recently approved extension of the waiver through 1987. The New Jersey system differs from the federal Medicare prospective pricing system in several important ways: First, it covers all third party payers, whereas the federal system covers Medicare only; Second, the New Jersey system covers all uncompensated care and the federal system does not; Third, rates are hospital-specific in New Jersey; Fourth, there are deliberate, due process appeals mechanisms which are more open than those in the federal system; Fifth, because New Jersey's system covers all payers, the DRG rates are set to reflect as closely as possible the resources consumed in each DRG by typical acute care hospital inpatients. Consequently, New Jersey has a much higher percentage of outliers (cases whose costs either exceeded or were significantly less than the DRG rate per case). The state felt that by removing atypical hospital inpatients from the average rate structure, quality would not be compromised. Sixth, outpatients are not excluded from the New Jersey system. They are billed on a fee per visit.[1]

It is important to note these six differences from the federal system, since they have a direct bearing on the incentives which dictate length of stay for hospital patients and the circumstances surrounding discharge planning for home health care.

IMPACT OF NEW JERSEY'S DRG SYSTEM ON HOME HEALTH AGENCIES

New Jersey's hospitals were phased into the DRG system over a three year period: 1980, 1981 and 1982. According to the New Jersey Health Department the average length of stay in 1979 (pre-DRG) for the seven most common types of licensed hospital beds was 7.43 days; this figure dropped to 7.0 days in 1982 and decreased farther, to 6.39 days in 1983.[2] By comparison, the Department of Health and Human Services reports a reduction in average length of stay in the Medicare program from 9.5 days to 7.5 days after the first full year of the federal prospective payment system.[3] Clearly, prospective payment results in earlier hospital discharges.

In a data report, compiled in cooperation with the New Jersey Department of Health, the Home Health Agency Assembly of New Jersey found that the number of admissions to home health agencies from hospitals jumped from 61% to 68% of total admissions between 1980 and 1981, the first year of phase-in for the DRG system in New Jersey. Since 1981, hospital referrals have remained a constant 67% of total admissions for home health care. We assume that this increase during the first year of phase-in reflects the adaptation to DRG's by all hospitals in the state, in anticipation of their being phased-in. The net impact of the DRG system is an increase of 8,000 admissions to home health care in 1983. There were a total of 133,000 persons served by home health agencies in New Jersey in 1983.

Over the same four year period during which the average length of stay steadily dropped, the number of high technology services offered by home health agencies grew dramatically. We lack good baseline data because in the early 1980's high technology home care services were in such an early stage of development that they were not included in the data questionnaire check-off list. However, according to 1983 data, the following services were offered by a significant number of home health agencies:

TABLE 1.—TYPES OF PROGRAMS AVAILABLE (1983)

	Number	Percent
Home catheter care [1]	50	98.0
Tracheostomy care [1]	45	88.0
Intravenous therapy	26	51.0
Respiratory therapy (MIA respirator)	17	33.0
Chemotherapy	13	25.5

[1] Catheter care and tracheostomy care are standard procedures and 51 percent of New Jersey home health agencies offer some kind of high technology service such as intravenous therapy or chemotherapy.

The growth in high technology services experienced over the period paralleling the DRG implementation years suggests a relationship between the two events, explained by the introduction of more acutely ill patients into the home health care setting.

The trend to expanded hours of operation—both business hours and service hours—is the most striking change in home health agency operations since the implementation of the DRG system.[4] 82% of home health agencies in New Jersey schedule admissions and visits seven days per week, and virtually all agencies provide emergency phone and referral service around the clock. Four years ago, only 66% of the agencies offered evening and weekend coverage.

POLICY CONTRADICTIONS THWART EFFECTIVE USE OF HOME HEALTH CARE

Home health agencies in New Jersey have responded to the needs of patients being discharged earlier, due to DRG's. However, agencies throughout the state report that they are thwarted in their efforts to develop appropriate plans of care by Medicare's definition of intermittent care and be gaps in private insurance coverage for high technology home health care services.

Federal policy contradicts itself. While the prospective payment system for Medicare hospital care is intended to reduce institutional care costs by reducing length of stay, Medicare home health policy guidelines require Fiscal Intermediaries to apply increasingly restrictive criteria in claims reviews. Patients who need high-tech care at home often require a daily nursing visit to supervise that care. Currently, such daily visits are frequently interpreted as not meeting the "intermittent" care requirement, and are, therefore, unreimbursable.

The "intermittent" care requirement was promulgated in the 1960's at a time when the types of high tech home care now available were not even anticipated as possible in the home setting. In the 1980's, this policy is myopic and contradicts efforts to contain health care costs. Why will Medicare pay for needed nursing services in support of high technology care in the hospital or nursing home, often at double or triple the cost, but not at home?

Private insurers have some catching up to do, too. Most policies lack home health care coverage, or pay for only a portion of the cost of care, rather than the 100% coverage of most procedures performed in an institution. This is a clear disincentive to use of less costly home health services for the post-acute patient.

In conclusion, we believe that the experience of home health agencies in New Jersey since the implementation of prospective payment for hospital care shows that it is high time for Congress and the business community to re-shape health care policies to remove this wasteful and inhumane policy contradiction. The number of persons falling into the "No Care Zone" is increasing. The problem needs to be addressed now.

Thank you.

DATA SOURCES

1. Faith D. Goldschmidt, Health Planning and Resource Development, New Jersey Department of Health, in a letter to "Modern Healthcare," August, 1984.

2. "Health Data Summaries for 1979, 1980, 1981, 1982 and 1983," New Jersey Department of Health.

3. "Medicare Limits Make Hospitals Careful on Costs," The New York Times, August 26, 1984, p. 1.

4. Taylor, M., "1983 Home Health Data—Home Health Agencies in New Jersey," Home Health Agency Assembly of New Jersey, Inc., "Princeton, NJ, March 1985.

Mr. SAXTON. Thank you very much.

Mr. Kauffman.

Mr. KAUFFMAN. I would like to thank the committee on behalf of the residents of Ocean County for holding this hearing here.

Mr. SAXTON. Would you identify your position?

STATEMENT OF CHARLES I. KAUFFMAN, JR., PUBLIC HEALTH COORDINATOR, OCEAN COUNTY HEALTH DEPARTMENT, TOMS RIVER, NJ

Mr. KAUFFMAR. Yes. I am the health administrator of the Ocean County Health Department.

Ocean County has been peculiar in that in the last two decades, especially in its aging population, the total population has significantly increased to the point that 27 percent of our total county population is now over the age of 60. That is over 90,000 seniors. Ocean County is also unique in that approximately 60 percent of the aged population reside in 40 retirement communities, which then does not lend the family support that you would have in the normal family situation.

With this history in mind, you must view the growth of the programs provided or supported through the governing bodies of Ocean County. The programs that have been provided are through the Office on Aging, the Ocean County Department of Human Services, the Mental Health Program, the Ocean County Board of Social Services, and the Ocean County Board of Health.

Also, as health officer of the county of Ocean and the director of the health department, I have had firsthand knowledge of the need to find alternative solutions to the institutionalization of our growing aging population.

One of the major reasons is that there has been a deficit in hospital beds, nursing homes, and other institutional facilities here in Ocean County for the last 20 years.

Ocean County has supplemented State and Federal programs by purchasing homemaker services for the medically indigent or the partially indigent patients. This has been to the tune of $750,000 to $1 million a year for homemaker services. These are patients not qualifying for other social or welfare programs. This supplementation has been a mainstay of the home health program, allowing the aged to cope with their problems and survive in spite of the lack of facilities during this period.

It should be recognized by now that health—home health care may be more expensive than institutionalization for some people, not, therefore, appropriate for all patients.

I would also like to bring out at this time that HMO's are not an option or available for Ocean County residents et this time. So, even though the HCFA representative did talk about it, it is not available here in Ocean County.

There has been some pilot programs initiated by the the inability to either pay privately and the inability of the Medicare Program to offer services for the aged population with chronic or supportive nonmedical needs. This must be addressed and changed.

I think everybody recognizes that Medicare had a problem with its inability to provide services and contain costs. However, HCFA and third-party payors have unilaterally decided to change services that have been covered or indirectly reduced by changing payments to providers, and especially in the home health care field.

This will continue to prevent, if not control, services from being delivered to the patients that should be provided or that is medically needed. I have attached and made part of the record a request from the Ocean County Advisory Committee of the Board of Health to investigate the reduction in denial of medical health care services under these newly instituted restrictions.

It is a fact that the efforts to reduce Medicare costs has reduced the length of hospital stays, requiring earlier and sicker persons—earlier discharge and sicker persons entering into the home care system.

I would like to tell you that the home health care industry has responded by accepting these patients into services, to later be denied payment for such services.

I would like to also say that there has been times when we have requested payment for skilled services that were needed on a daily basis only to be told by the fiscal intermediary that continuous daily visits for skilled care for changing dressings would be denied if continued for an extended period of time, maybe over 3 weeks as an inappropriate discharge from the hospital.

And, I would like to say that many of these patients do not need hospitalization, but they do need the skilled nursing care provided in the home, and they are not necessarily inappropriate discharges from the hospital.

I see HCFA working on both ends and just forcing the patients out of the system. It must be realized that the elderly patients without young family support must have outside services or a home health care system will fail. The Government has promised health care for our elderly as an insurance program called Medicare. Normally, insurance specifies in great detail its benefits and limitations by contract.

This does not seem to be the case for Medicare. Medicare benefits change daily, causing great difficulty for the patients and providers alike. If Blue Cross did this, or Prudential, or some other insurance company, they would be out of business real quick because Government and the legislature would put them out of business.

The best alternative system that could be developed would be to clearly identify the eligible services and limitations to the Medicare Insurance Program. Number One.

Then, the program should allow for the purchase of added services, not now available, to include long-term nursing home facility care, full payment of physician charges. Right now, physicians are only getting—well, physicians are not billing Medicare systems, for the most part. The individual patient has to pay him, and they get about maybe 50 percent of what it costs them to pay those services. And expand home health maintenance services, thereby not requiring senior citizens to become destitute before qualifying for institutional care or alternative programs.

Thank you.

[The prepared statement of Mr. Kauffman follows:]

PREPARED STATEMENT OF CHARLES I. KAUFFMAN, JR., PUBLIC HEALTH COORDINATOR, OCEAN COUNTY HEALTH DEPARTMENT, TOMS RIVER, NJ

I would like to thank the committee on behalf of the residents for holding this hearing in Ocean County. It should be recognized that this County has had an explosive growth in the last two decades, especially its aging population. The total population of this County in 1960 was only 108,000, in 1970 the total population was 208,500 with 45,000 over the age of sixty. In 1980 this total population expanded to 346,000 with the over sixty population doubling to 92,927 persons, representing approximately twenty-seven percent of our total County population.

Ocean County is also unique in that approximately sixty percent of the aged population reside in forty retirement communities. It is with this history in mind that you must view the growth of the programs provided or supported through the governing bodies of the County. They are the Ocean County Office on Aging, the Ocean County Department of Human Services, Mental Health Programs, the Ocean County Board of Social Services and the Ocean County Board of Health.

As Health Officer of the County of Ocean and the Director of the Health Department, I have had first hand knowledge of the need to find alternative solutions to the institutionalization of our growing aging population. This increase in senior citizens has forced the health care community to develop programs to service this fast growing segment of our population. Ocean County has had a deficit in hospital beds, nursing homes and other institutional facilities in the last twenty years also requiring alternative solutions to these problems.

The County of Ocean has provided public health nursing services for over fifty years. In 1970 a staff of twelve nurses provided home care services for the entire County. This, however, has been expanded to a total health care organization of over 170 full time personnel supplemented with an additional 100 part-time and contractual employees.

The home care division of the Ocean County Health Department provides the following services on a regular basis seven days a week: Nursing, Physical Therapy, Speech Pathology, Occupational Therapy, Medical Social Services, Nutritional Services and Home Health Aide Services. Night services are provided to hospice patients and all patients have access to a twenty-four hour answering service. A major component of any program of home health services must above all include home health aide/homemaker services.

The County of Ocean has supplemented state and federal programs by purchasing homemaker services for medically indigent or partially indigent patients (these are patients not qualifying for other social or welfare programs). This supplementation has been the main stay of the home health program allowing the aged to cope with their problems and survive in spite of the lack of facilities during this period. It should be recognized that by now home health care may be more expensive than institutionalization and therefore not appropriate for all patients.

The State of New Jersey has instituted a program entitled "Community Care Program for the Elderly." The purpose of this program is to attempt to deinstitutionalize patients. There are selected individuals who can manage in their homes with additional in-the-home services yet were originally institutionalized because of their inability to pay for these services or have them covered by Medicaid. This is a small, three (3) year demonstration program limited to a total of 1,800 slots; at the rate of 600 slots per year. The program will provide the following services: Home Health Care; Medical Day Care; Non-emergency Transportation; Case Management; Social Adult Day Care; Homemaker Care; and Respite Care.

These services are limited to 70% of the long term institution costs for those individuals that have an income of less than the Medicaid institutional cap.

We; therefore, return to the crust of the problem: financial eligibility, the inability to pay privately, and the inability of the Medicare Program to offer services for the aged population with chronic or supportive non-medical needs. This must be addressed and changed.

The populous throughout the nation has recognized a problem of Medicare to be its inability to provide services and contain costs. However, HCFA and third party payors have unilaterally decided to change services that had been covered directly or indirectly by reducing or changing payment to providers. This will prevent, if not controlled, services from being delivered to the patient that should be provided or that is medically needed. Attached and made part of this testimony is a copy of the request by the Ocean County Advisory Committee of the Ocean County Board of Health to fully investigate the reduction and denial of medical health care services under these newly instituted restrictions.

It is a fact that the efforts to reduce Medicare cost has reduced the length of hospital stays requiring early discharge and sicker persons entering into the home care system. The home health care industry has responded by accepting these patients into services to later be denied payment for such service. It must be realized that elderly patients without young family support must have outside service or a home care system will fail.

The government has promised health care for our elderly as an insurance program called Medicare. Normally, insurance specifies in great detail its benefits and limitations by contract. This does not seem to be the case for Medicare. Medicare benefits change daily causing great difficulty for the patients and providers alike.

The best alternative system that could be developed would be to clearly identify the eligible services and limitations to the Medicare insurance program. Then the program should allow for the purchase of added services not now available to include long term nursing home facility care, full physician payment of charges, and expand home health maintenance services thereby not requiring senior citizens to become destitute before qualifying for institutional care or alternative programs.

The Health Advisory Council of the Ocean County Health Department, established in accordance with the Code of Federal Regulations Title 42 Public Health, would like to identify a persistent problem confronted by the Ocean County Health Department while attempting to provide home health care services to the senior citizens in your constituency. For years, our agency has been providing home care services to those in need. It is our understanding that in recent years Congress has established policies to expand home health care services for the elderly. The problem is that the legislative intent and mandate seems to be impeded by the fiscal intermediary who reimburses our agency for home health care services.

Examples of recent medicare patient denials are as follows: A ninety-one year old woman who is cared for by her eighty-five year old spouse. She is essentially homebound, confused, and requires catheter care. A home health aid had been providing extensive personal care on a daily basis. However, the fiscal intermediary denied reimbursement for daily home health aide services and granted payment for only three visits per week because they determined that the patient required only supportive rather than necessary aid. The home health aid provides specific services, such as bathing, washing hair, cleaning teeth, preparing meals, etc. for a period of two hours per day. Without these services, the sick, elderly client cannot be maintained as independently and cost efficiently as possible in the home. The agency should be able to render efficient home care services as they are needed.

Another eighty-seven year old patient, who lives alone, was homebound due to multiple injuries sustained by a fall. During the fall, she badly bruised her face and fractured her wrist. She underwent surgery for her left wrist injury, and a cast was necessary to immobilize her left arm. This essentially left her homebound and unable to care for herself because of the cast and other injuries. The intermediary determined that she was ineligible for home health care because she was able to ambulate.

The fiscal intermediary has determined that home health care service is excessive for patients who receive visits for daily dressing changes for more than two weeks. The fiscal intermediary requests additional documentation as to the need for home health care and even when it is provided the claims are denied. Complying with the fiscal intermediary's interpretations of these regulations, places a tremendous burden on the resources of the home health agency.

These are only a few of many cases on record. Since January 1, 1985 a number of claims have been denied resulting in a loss of revenue. In other words, services have already been provided and are not being reimbursed.

The physicians and others on our Health Advisory Council are appalled at the insensitivity of the fiscal intermediary to the essential need of our seniors and believe that they are acting in a fiscally irresponsible manner by not reimbursing for the seniors' health care needs. At our last Council meeting, a physician member stated that: "The government sends billions of dollars to foreign countries for does not allocate enough funds for the essential health care needs of our seniors."

In order to resolve this problem and assure that administrators are following the intent of your legislation, the Council believes that an investigation must be instituted by you and your colleagues to examine the policies of medicare and its fiscal intermediary. Is it better to save money or lives?

Sincerely,

HEALTH ADVISORY COUNCIL.

Mr. SAXTON. Thank you very much.

Ms. Hines, would you move the other mike so the reporter can hear you?

Ms. HINES. Yes.

Mr. SAXTON. You are the deputy director of Ocean County Board of Social Services, I believe?

Ms. HINES. Yes; I am.

Mr. SAXTON. Right. Thank you very much for coming. We appreciate it.

Ms. HINES. Thank you.

STATEMENT OF PATRICIA HINES, DEPUTY DIRECTOR, OCEAN COUNTY BOARD OF SOCIAL SERVICES, TOMS RIVER, NJ

Ms. HINES. Thank you for having this hearing today in Ocean County, and I would like to suggest my recommendations to the committee. Ocean County has become sort of a research laboratory for what I will suggest to you is a program, a delivery mechanism, for examining this issue of long-term care and continual care.

Ocean County Board of Social Services administers approximately 20 social- and health-related services to the older adult population in this community in cooperation with such groups as hospitals, the Ocean County Health Department, home health agencies, and the like, and one of our recent experiences has been with the case management and income eligibility aspects of the two Federal waiver programs, model waiver, and community care programs for the elderly and disabled under Medicaid.

And, it is from this experiential base that we find that—we look at income eligibility determinations and a number of people are not eligible for long-term community care under this program.

We look at the limited number of slots available under this program and there is where a number of people are not eligible and are now facing a waiting list.

And, we have ambivalence regarding the cost effectiveness of home health care delivery as reflected in the reimbursement policies under the various programs. Medicare and Medicaid, the waivers, and so forth. We look at a limited number of services that may be involved in each of these programs of a medical and social nature.

And, we look at the fact that institutional care needs are met, shelters, energy needs, medication, food. We do not see this in our community care program design by the very nature of limiting ourselves to a medical, or insurance, or social welfare-type approach.

Under the community care waiver program for the elderly and disabled, we found that it is cost effective. In our examination of our present caseload, we find that clients are able to receive services at less than the 70-percent cap of long-term care costs in institutions. More that a third of our recipients are at 50 percent or below the cap for expenditures.

Only 16 percent are utilizing between 90 and 100 percent of the cap for financial reimbursement services. Therefore, what we would like to suggest is that we design a program that meets both the social and health related needs, persons in long-term community care, without regard to involved, contrived medical monolog of income eligibility, designate health services.

We need to look at the fact that the individual residing in the community has other than medical needs. The suggestion of allowing the an SSI level of home-based maintenance is insufficient in most cases, and we recognize that there needs to be provisions for unpredicted housing problems, the toilet breaks down, the furnace is down, the roof has a leak.

The issue of transportation for social and needed services, nutrition. The Older American Act certainly provides some of these needs, but not in an integrated manner.

We only need to look to social service block grants about the use of some of their social—some of their discretionary funds to meet these other needs to see that we need a more integrated approach, collapsing the social and medical needs into one title perhaps to experiment with other service deliveries, where you have an integrated approach of health and social services.

I think I will close my remarks there.

[The prepared statement of Ms. Hines follows:]

PREPARED STATEMENT OF PATRICIA HINES, DEPUTY DIRECTOR, OCEAN COUNTY BOARD OF SOCIAL SERVICES, TOMS RIVER, NJ

For too long we assumed that "gone were the days when families wanted to keep their elderly and ill loved ones at home". Rather we find and Chicago Sociologist, Ethel Shanas, confirms, that the opposite is true, but the health care structure that has developed over the past decades has incorporated within the delivery system an institutional bias.

Given the means to provide necessary care for their elderly and disabled, families and communities are willing and want to keep them at home.

Through our work at the Ocean County Board of Social Services with existing and newly established programs, we continue to learn and refine our skills in the delivery of community based home health care. Our experience providing social services to the elderly and disabled population and as the case management site for the

Community Care Program for the Elderly and Disabled and the Model Waiver Program, has brought us to an awareness of the need to review the home health care system as an element of community based long-term care. As more and more individuals avail themselves of home care rather than institutionalization, we must strive to provide the best and most cost effective service to meet their needs.

Through our involvement with the Community Care Program for the Elderly and Disabled over the past two years, we have seen the advantages of offering an alternative to institutionalization. The inability of the care taker to provide necessary care coupled with the financial burden of home health costs has caused many families to choose institutionalization. Society attempts to suggest we should take care of our own, but without adequate support systems, families are destined to fail. The emotional toll on the patient and family is catastrophic.

Ambivalence regarding the cost effectiveness of home health care is reflected in the reimbursement policy for home health services. The United States Department of Health and Human Services has defined home health care services with recognition of the need for service coordination. Service components include dental, nursing, social work, pharmacy, laboratory, physical, speech and occupational therapy, nutrition, homemaker-home health aide service, transportation, chore services and provisions for medical equipment and supplies. Existing programs do not include all services and many are limited to specific populations with fragmented services.

Medicare reimbursement is limited to services requiring skilled nursing care or physical and speech therapy. Medicaid differs slightly in that skilled care is not a condition for receipt and there is more flexible coverage of services for the chronically ill. Income and resource eligibility though limit accessibility.

Recent waivers of federal regulations have removed some barriers and several waiver programs in Ocean County have demonstrated the effectiveness of home health care versus institutionalization.

The Community Care Program for the Elderly and Disabled has demonstrated that home care can be more cost effective than institutionalization. The Service Cost CAP on patients being served is limited to 70% of the average long term care facility cost per month. More than one third of the recipients of the program utilize only 50% or below of the CAP. Only 16% utilize between 90-100% of the CAP. The recipients are medically in need of long term care but when they receive minimal professional support and a coordination of services are able to remain at home.

The cost effectiveness of the program can be evidenced by cost containment to within 70% of the institutional cost. The social and emotional benefits are significant although often immeasureable.

The expansion of this type of program can only serve to improve the delivery of health care to the homebound. However, the eligibility requirements and health care services of these programs need to be reviewed and revised with an emphasis on the special needs of those at home.

Provisions are made within existing programs to provide for basic health care. The individual at home though is not identical to the individual in a health facility. Their home environment, family and community all factor into the treatment of the individual. Institutional care meets an individuals total survival needs. Third party carriers reimburse the cost of not only health services but food and shelter costs. Home based services recognized and reimburse limited services and do not include recognition of total survival needs.

Recognizing the community based social needs for such needs as housing, transportation, nutrition and income support coupled with health needs brings us to a logical conclusion. A new title should be created that would enable the Case Manager to provide a full scope of services: health and social to avert institutionalization. We can learn much of the discretionary social needs from a study of those services to recipients of Social Service Block Grants directed to prevention of institutionalization. But we must integrate the service delivery system so that the case manager has a full array of resources available in establishing a care plan. We can learn from the Community Care Program for the Elderly and Disabled cases that there is a surplus of designated funds. Why not structure the law to allow the Case Manager to spend those funds on necessary social needs up to a CAP or ceiling.

Thank you for the opportunity to express these comments to you.

Date: June 14, 1985.

BEVERLY J. BEARMORE,
Director of Welfare.

Mr. SAXTON. Thank you very much.

Ms. HINES. Thank you.

Mr. **Saxton**. Sister Teresa Confroy, public health nurse, Ocean County Health Department. Sister, thank you for being with us.

Sister **Confroy**. I am the stepchild here.

STATEMENT OF SISTER TERESA CONFROY, R.N., PUBLIC HEALTH NURSE, OCEAN COUNTY HEALTH DEPARTMENT, TOMS RIVER, NJ

Sister **Confroy**. Thank you. It is quite an honor to be here and I would like to say that to you, Congressmen, and to the brave souls who are still here, sitting in this very warm room.

My remarks are based mainly on the patients. You have heard from local authorities, people at government level, and agency level, but my remarks are basically concerning the people that we care for here in Ocean County.

I am a staff nurse at the Ocean County Health Department, which is a home health agency that is Medicare approved.

One of our big problems with the patient is that when someone becomes 65 years of age, they receive a blue book, and the blue book is the Medicare guidelines that they receive, and in it, is the very well written book and it states what the patient feels he is entitled to, and one of the things that, according to this blue book, that everyone has over 65 years of age, is that he is entitled to home health care.

He may have home health care which is care given to him in the home, if all the following your conditions are met.

No. 1, the care includes part-time skilled nursing, physical therapy, or speech therapy. Two, this particular patient is confined to his home. Three, a doctor determines what you need and writes a plan of care, and, four, the home health agencies, such as ours, is a service that is participating in Medicare. No problem.

The second sentence of that pamplet, which is one of the opening sentences, by the way, says that once the above guidelines are met, the insurance can pay for unlimited number of home care visits. The statement is correct as is it stands. It is the interpretation that is the problem, and it seems to me that a lot of the problems that I, as a staff nurse, encounter is the interpretation and who is interpreting what the Medicare guidelines are.

Not a day goes by in the home care agencies such as ours, the Ocean County Health Department, where the mailbag has denials for service. It is an every day occurrence, and I am sure other agencies would say the same thing.

The patients feel they are entitled to care. They feel the need, and, in most cases, they do have a need. Yet, in order to provide the service to county residents, the agency must find other sources of payment, be it the county, be it some other type of insurance program, if there is one, the patients themselves, and, hopefully, this does not happen, the patient does not get care.

That is our concern. A concern surely is the money, who is going to pay for this, but that is not our main issue; our main issue is that people are being denied care because they do not qualify for some sort of guideline.

I would like to just share a few examples. I know you have heard some very good examples of lack of care, and I do not want to detain you with too many, but the question of the care of the patient who is discharged from the hospital, who requires intensive or long-term care, is a major problem.

Consider, if you will, this particular woman that we service. She lives alone. She is a diabetic. She is arthritic. She is very obese. She was in the hospital for many days, for months, in fact, for care of an abdominal condition. She has returned home now because her hospital benefits are over, and she requires daily dressings, which includes irrigation of her wound and packing.

She is seen by her doctor periodically. She is making good progress, but do not forget she is diabetic, she is elderly, and she needs care, and it is going to take awhile for this wound to heal.

We were able to visit her for 1 month on a daily visit. After 1 month, we are no longer able to visit her under Medicare because her days for care are not covered by Medicare payment. We are able to scale down the amount of payment that can be received. We will contunte to visit and she is still our patient, so we do not neglect our patients, but Medicare is no longer picking up the tab to pay for this woman's care. Yet, the woman feels that she is entitled to this care as outlined in her guidelines.

The patient thought she could have these visits because the book said unlimited, but unlimited does not mean unlimited.

We have other patients with physical deformities. We have patients who live alone and many of our patients down here live alone, and some of the previous speakers alluded to lack of family members. We often find down here the burden for care falls upon an elderly neighbor, and an elderly neighbor starts off as a good samaritan caring for someone and finds that they can no longer do this job, and the patient needs care and they are not able to do it.

So, the burden is on the family support, if there is a family, and, very often, it is on a neighbor who is not able to care for the patient at all, let alone care for themselves.

We also have down here in the retirement villages, 90- and 95-year-old parents caring for 65- and 70-year-old children, and that is a very devastating problem because they are waiting and waiting, hoping, hoping that they will outlive the patient who is sick, so they can provide the care. That is a big problem that we face.

We also have the poor patient, who gets up in the middle of the night, falls, breaks her arms or her shoulders or dislocates her arm, goes to the emergency room, is wrapped in some type of a dressing, and is sent home. Under the guidelines, patients with upper extremity disorders are not covered by Medicare for home care. She is sent home from the hospital because she does not qualify for hospital care either. She is sent home, she cannot wash, she cannot dress, she cannot take care of her basic personal needs.

She could use a homemaker, and if we can arrange in some way or other to have some type of funding, if available, for this particular patient, we will try to put one in, and, very often, the request for physical therapy, when she is able to have therapy, is denied.

We—I had a gentleman who had cancer of the throat. He had his voice box removed, and also he was cardiac hypertensive. Now, the patients all have more than one diagnosis. They are not simple cases.

This gentleman came home, his wound healed well, he was started on speech therapy, which is a covered service. The doctor wishes him to learn what they call esophageal speech in order for him to communicate again. He did very well. His progress was good, but it took time. Medicare will pay up to 6 to 8 weeks of speech therapy in the home. This man, making very good progress, took 6 months. Medicare denied payments beyond the 8 weeks.

The other thing about the denial, which was alluded to before, your payment is not denied today, your payment might be denied 4 months from now, for a period 3 months before that.

So, you try to figure out what gets paid for and what does not. It is very difficult task for those who have to worry about the money problems. We are lucky, we as nurses can go out and provide the service, but it is somebody else's problem when it comes down to who is going to pay the cost.

The whole question of homebound is another big issue. Many patients down here have chronic problems, have heart problems, lung problems. They never go out. They never leave the house. They could not go out if you paid them. Most of the transportation here in the villages is by bus. These poor souls could not get on a bus if you paid them to get on the bus. It is just impossible.

If we get a call to go into the house and take the blood pressure, listen to their lungs, et cetera, that payment sometimes is denied because they are not considered homebound.

Then, we have the whole area of chronic patients, the Alzheimer patients. You have heard about them and you have seen about that. The Parkinson patients. The patients with osteoporosis who really get nothing as far as skilled service, they just live in constant pain, constant lack of mobility. They need help that is not available for them under a skilled service framework.

We could go on and on with stories of patients. I know that time is running short. All the experts tell us that hospital care is much more expensive than home care, that it is cheaper to send someone home and that premise is true. But, when patients get home, there has to be some way for them to provide the care that they need, whether it be skilled service or some type of ancillary service.

The last thing they want to do in life is to accept welfare, to accept charity. If they even have a suspicion that you are offering them some State or county program, they will have no part of it. They will do without the care rather than ask for a handout. That is the reality of many of the people we deal with.

Also, too, we have many people in Ocean County who have come from out of State, and have retired here. They feel they are covered by home care benefits through their pension programs, through their retirement programs; very often, they are not covered at all because the program only covers them for inpatient care, not for home care. So, there again, they are stuck.

Our stories seem endless, the patients' problems magnify, the patients skimp on food, they skimp on heat, utilities, to pay for a doctor, to buy medication. They have to rely upon others to take them wherever they wish to go. It is costly to get a taxi down here in Ocean County as well as any place else in the State.

They begin, then, not to take their medicine. They begin to get sicker. They go back to the hospital. They are kept in the hospital for a few days, they are sent back home, this time weaker, the cycle speeds up, the revolving door keeps moving, and, at some point, everything seems to stop for some of these patients.

It might sound hopeless for some and for some, I am afraid it seems hopeless to them. For others, they have some hope because they know that there are people who may be willing to try to fight for what they need. Some of them are too old to worry even now. They figure all this hoolabaloo over Medicare and Social Security, they are not going to be around.

So, it is the younger older group who are most concerned, will these benefits be available for them? Will we have programs that will be able to help them? Hopefully, one of the reasons that we are here today then is to air some of these problems. They are not all of the problems, but just some of the problems that we face, and we just hope that some of these stories will be remembered by our legislators, by our elected representatives here today, and we hope that they really do care about the people that they serve.

We hope that when they go back to Congress and they get back into committee work, that they will be able to work together as a team to help to effect some change that will affect all the people. We would be naive to think there have not been some misuse of Medicare. I mean, we could tell you just as much misuse as we can of no use for Medicare at all, but we just hope that our Congressmen and our people can work together to try and make some things happen for those who are left now to face what health care will be in the future.

Medicare was a good, a good thing, when it was instituted. It was made in good faith, and we would hope that the people now who have the responsibility given to them by us to see that this is carried through will continue in good faith to help the residents of this Nation and of this county.

Thank you.

[The prepared statement of Sister Confroy follows:]

PREPARED STATEMENT OF SISTER TERESA CONFROY, R.N., B.S.N., M.S.N., PUBLIC HEALTH NURSE, OCEAN COUNTY HEALTH DEPARTMENT, TOMS RIVER, NJ

The most recent Medicare Handbook states: "Medicare can pay for covered home health visits furnished by a participating home health agency. Medicare can pay for home health visits only if all of the following four conditions are met: (1) the care you need includes part-time skilled nursing care, physical therapy, or speech therapy, (2) you are confined to your home, (3) a doctor determines you need home health care and sets up a home health plan for you, and (4) the home health agency providing services is participating in Medicare."

These statements seem clear and concise. The individual needing care seems to comprehend this without too much difficulty. It is the next sentence in the Handbook that causes the concern, confusion, and frustration for the patient and caregiver. The Handbook states: "Once these (the above outlined) conditions are met, either hospital insurance or medical insurance can pay for an uplimited number of home health visits." The statement is correct as it stands; its interpretation is the problem.

Not a day goes by in a typical home health agency such as ours, the Ocean County Health Department, that the incoming mail does not contain medicare denials for service. The patient feels he needs, and in many cases does need assistance; yet, in order to provide needed service, the agency must find other sources of financial reimbursement or suffer the loss. The federal government is saving, cutting back, keeping costs under control—usually at the personal expense of the agency, county, or individual patient. The money issue is a real one; but the greater issue for us in home care service is the potential for lack of service to those in need of these services.

Permit me to share with you a few examples of patients who were denied nursing care or a specific therapy because of the interpretation of the Medicare guidelines. Keep in mind that the patient feels and knows (according to the Medicare Handbook) that he is entitled to service/help.

The first guideline informed us that the patient is entitled to part-time nursing care. It's not too difficult to explain to the patient that the nurse does not stay with him in the home. He understands that she will come in on a definite routine as indicated by the physican's orders for his care. No problem. What the patient does not understand (and truthfully, very often, we, the nurses do not understand either) is Medicare's interpretation of part-time nursing care. They use a fancy term to describe nursing care. They call it intermittent care. This definition creates a distinct hardship for patients requiring wound care. I'm not referring to the routine hip pinning or gallbladder or ulcer patients. I am referring to the elderly patient, who lives alone, who has been discharged from the hospital—often after a lengthy stay for post-operative complications—and who in no way is able to do his or her own wound care. Usually the patient's hospital benefits are all used up.

Consider, if you will, Mrs. B. who lives alone and now finds herself in need of assistance with wound care. She lives on social security benefits and some savings. She is obese, diabetic, and arthritic. She has had extensive abdominal surgery. Her wound now requires daily irrigation and packing. Her abdomen is large and her gaping wound is huge. She has a large amount of drainage. She is seen periodically by her doctor and he is satisfied with her progress. The wound is healing slowly now after a month of daily visits. This patient will require continued daily visits but Medicare will no longer pay for them, even though it is physically impossible for her to do the daily care. The nurse will continue to visit, but who will pay for these visits? The patients? The County? The patient thought that she was entitled to unlimited visits.

Or consider the patient with Spina Bifida—a congenital, lifelong deformity of the spine. This patient had a wound on his buttocks. It will take months to heal. Once again, we have a person phsically unable to do his own care. The nurses will continue to visit daily, but Medicare will not pay for these daily visits. The fiscal intermediary considers the condition to be chronic rather than an acute care need.

Think about the poor woman with bilateral fractures of her shoulder bones. Mrs. G. is totally unable to care for herself.

She is immobilized. She cannot wash or dress herself, let alone take care of her own very personal needs. Initially, she needs the services of a home health aide, but medicare will not pay for this service. In time, she will need physical therapy, and once again she will not qualify for their help. Her diagnosis is not one that is covered by medicare.

There are many women patients suffering with osteoporosis. They need care and assistance. Often, the pain is unbearable! Their mobility is limited. Because of their chronic condition, federal funds will not cover their care at home. They are not candidates, for admission to the hospital. What are their alternatives?

Mr. R. developed a cancer of the throat and vocal cords. He is also a cardiac and hypertensive patient. He lives alone and relies on social security and minimal savings to get by. His voice box was removed, and now he must learn to speak using Esophageal speech. His physician orders speech therapy—a covered service. His progress with therapy is good, but this type of therapy takes a long period of time to learn. Medicare pays for six to eight weeks of therapy. It took six months for the patient to learn this technique and to be able to function again in society. The fiscal intermediary denied this man's medicare payment beyond the first eight weeks.

Medicare requires that a patient be homebound to receive home care. We have cared for numerous patients suffering from respiratory and heart problems. Their conditions have debilitated them so that you might refer to them as feeble. They never go anywhere. They couldn't get into a bus—the main type of transportation in the retirement villages—if they tried. Often, they are eighty-five to ninety years of age. Use of oxygen and breathing machines are part of their daily routine. Yet, the fiscal intermediary denies the visits for vital signs (blood pressure, heart rate, lung sounds, etc.) because they consider the diagnosis not one that necessarily requires them to be homebound. The fiscal intermediary considers their condition as being chronic.

Last, but not at all least, for your consideration are our chronic care patients—especially, our Alzheimer's patients. The plight of those patients and their families is now being publicized in the media. They require constant daily care and are a tremendous burden for those at home trying to provide their care. Again, many of these patients do not qualify for medicare coverage—let alone any other type of funding. Their problems are real. Many of them require feeding, total personal care, and constant safeguarding against injury. Their care is demanding and draining on the caretakers; yet, medicare does not provide any source of payment for this care.

Mr. G. is responsible for his wife's care. Often, it seems that she does not even know her husband of fifty-five years. She needs total physical care, feeding, and safe keeping. It's a twenty-four hour job and hopefully, Mr. G. will stay well enough himself—he's eighty years old—to provide this service for his seventy-five year old wife.

All the experts tell us that it is cheaper to maintain a patient at home. In these days with the tremendous cost of hospital care, this premise seems true. There is no question that the majority of patients are happier and more content to be cared for at home; but for those patients who are not "cured" within a limited time frame, the cost of home care can wipe out all their savings—if they have any. The most affected patients are those who either own their own homes and/or have some savings. They must pay full price for their medications, supplies, and transportation. In Ocean County, many patients have moved here from other states. The supplemental insurance they have as part of their retirement benefits does not cover home care needs in New Jersey. These are individuals trying to take care of their health needs and the last thing they want is to go on public assistance/welfare. It is contrary to all that they have worked for and stand for. They refuse service if there is any hint that they might be accepting charity. The cycle of their illnesses speeds up. They skimp on food and utilities to pay for medications and doctor bills. As they are no longer able to drive (and in the case of many elderly women, they never even learned to drive), they have to pay someone to take them wherever they need to go. Still within the progression of the cycle, their health deteriorates—they are sent back to the hospital, kept for a few days, and returned home, a little weaker.

The story seems endless. How do we resolve these real problems? How do we, as a concerned group of individuals, maintain society's faith in a Health Care system? Many of those affected are too old or too sick to fight the battle. What are their options? This meeting/hearing today is one small step toward resolution of the problems. Hopefully, our elected leaders will listen to these stories and by their actions demonstrate that they really do care for the people whom they represent. We hope that they will be able to influence their peers to work together to effect changes in the Medicare guidelines, so that the intent of the original legislation can truly allow the majority of people to profit from the federal health care program.

Time is running out for some of our senior citizens. Hopefully, there is enough time left for our elected leaders, our health care personnel, and you, our concerned citizens, to work together to make these changes happen.

Mr. SAXTON. Thank you very much. It occurs to me that you have brought up a problem which is quite serious, and I do not think it is one that Congress intended to create. Mr. Kauffman pointed out that there were three things that needed to be done, the last of which was to expand home health care, which prompted me to immediately turn to my briefing notes because I remembered reading a paragraph that the Sister referred to. The paragraph says, "Currently, the Medicare statute, pursuant to amendment, made on July 1, 1981, Public Law 96-499, provides coverage for unlimited home health care visits for beneficiaries qualified to receive such care."

And, as the Sister pointed out, to qualify for home health care services, the Medicare beneficiary must be confined to his home, be under the care of a physician in addition, the person must be in need of part-time intermittent skilled nursing care and so on.

So, the intent of Congress apparently as of July 1, 1981, and as explained by that language, was to provide home health care, and a good supply of it, if you will. And, yet, from what you all are telling us, that is not happening. Is it because something has happened that my notes are wrong, or is it that the Medicare procedures have been interpreted in such a way that these services are not provided in spite of the law, or is it that the Medicare fund is so low that the money is not there to support it?

Would anyone like to react and tell us what the problem is? We are trying to get at the root cause. What we are trying to point out is that the law provides for home health care. It seems to be very clearly stated, and, yet, the testimony this morning is that home health care is very limited, far from full service health care provided for in the 1981 statute, and what we are going to try and do now is to get an answer from, I guess, Mr. Kauffman. He is going to answer us, to tell us what has happened since 1981, so that the law is not being carried out as it is apparently written.

Mr. KAUFFMAN. There are two things I would like to say. First, I believe my testimony alludes to the fact that HCFA and the third party payers have made different interpretations of your regulation, and I do not think their interpretation is the intent that Congress had intended, and I think that you need to investigate this. I think their changes have been focused on only one thing: money. And, I think they do not give a dam about the patients, and I do not think they ever will care about the patients.

The other thing that I would like to say is that when I talked about expanding home health care and so forth, it was not home health care as much as home health maintenance services.

The reason I want to say that is because I am trying to get away there from the medical model. I think there are many senior patients that do not need skilled care but need that homemaker in the home to assist them, cook, to pick up groceries to some extent.

You have got to remember that here in Ocean County now, many of our seniors that first moved in 20 years ago, to our first residential community, are—that was 20 years ago, 1965. It is now 1985. If they moved in at 65 years of age, they are 85 years.

Some of them are even older than that and are unable to drive. A husband gets ill and the wife never learned to drive. They came from Newark or from Philadelphia. They have never learned to drive.

They are dependent upon somebody else to do those chores and errands from outside the home. The husband may be just incapacitated by a stroke or something and does not need any longer need for skilled care, but they need help in the home. A good example of another type of situation just the reverse, the wife becomes ill, the husband never cooked a meal in his life, yet he is now the sole caretaker of that family. He has to provide the meals and help cook. A homemaker can assist in that, and that is what I am talking about, expanded home health maintenance services.

Ms. HINES. Could I add a comment to that, that my suggestion about an integrated health and social model is simply that, that if we could do a demonstration project to show that combining social and health-related needs, within the discretion of the case manager, I think we could demonstrate that letting the case manager select the services that the person needs as opposed to being programmed to finding the services, would be, I think, a very good demo project, and I cannot think of a better place to learn that than in this county.

Mr. TAUKE. I agree. Thank you.

I first want to thank the panel for very good testimony. You certainly have raised a lot of issues. But, let me just ask, I think, a single-key question, and that is, what are the things that are being denied? Is there a pattern to it? Where do we find out what the policy is that is being reviewed by the health care financing administration, interpretation of the regs, that differs from your own interpretation?

Mr. **Marosy**. According to the survey that we conducted this spring, the denial areas most frequently experienced were in home health aides, physical therapy, daily nursing and medical social work under Medicare. Sixteen agencies cited denials for home health aide service in excess of 3 days for 2 hours at a time per week.

Mr. **Tauke**. Now, if I may interject, why is it being denied? Why is home health care, home health aid being denied in some instances and being approved in others? What is the dividing line?

Mr. **Marosy**. The entire system proceeds from the screens or guidelines that are given to the fiscal intermediary that processes the claims, and that is Prudential here in New Jersey.

They have to meet certain targets for the processing of these claims, and the particular interpretators are left up to the staff, some of whom are qualified and some of whom are not, working for the fiscal intermediary.

Mr. **Tauke**. If I may interrupt again, meet specific targets. What do you mean? In terms of total dollars spent?

Mr. **Marosy**. Right. Certain dollar savings that are expected from each of the fiscal intermediaries throughout the country, and what we are saying is there has not really been a close scrutiny here. It is very myopic, very narrow looking at home health care. Just as they set targets to serve on hospital care, they set targets for serving home health care, not realizing that one might need to grow at quite a large rate to make up for this treatment that is occurring in the other area.

Mr. **Tauke**. And, are you able to predict if you are a home health care provider, are you able to predict what will be approved and what will be denied?

Mr. **Marosy**. If we had that consistency, we would be on first base.

Mr. **Tauke**. There are two problems. One is that (*a*) you just do not think enough is covered, and (*b*) there is inconsistency, uncertainty about reimbursement.

Mr. **Marosy**. Absolutely. Maybe one of the direct care providers here can address that better than I.

Mr. **Kauffman**. Let me say that a year ago, we would put a nurse or assign a nurse to a patient that needs skillful care on a daily basis, and have no trouble on its—on the question of whether it was denied because we did case work on it. All right. And, the nurse did a good job, and we have good nursing staffs.

Now, even that type of thing, after 3 weeks, they say it is no longer needed. Well, it does not go away, and it will be the same case that we did a year ago. The same thing with the homemakers. We have historically been able to have homemakers for certain types of cases in five times, seven times a week, come in and put patients to bed and so forth. This is continually being denied. It is new, it is change.

Mr. **Tauke**. Is there an appeal procedure?

Mr. KAUFFMAN. Yes, but you have to understand the appeal procedure is twofold. One, in order to really get an appeal, it has to be over *x* number of dollars and then you have to go down to Maryland to appeal it. If it is under—some times, it does not pay to take my staff—and, then, you need to bring the patient in for the appeal process.

Now, the patient, when there is retroactive denial, is not asked to pay the claim because that was the agreement that he signed with the Medicare program, that if we provided inappropriate care, it was denied, the patient is not charged for that care. Retroactively.

But, the patient, if you are going to appeal it, the patient has to get involved in the appeal process, and many of the patients are homebound. They cannot get involved in the appeal process.

So, the whole thing, as it relates to home care, is ridiculous, and unless you go as an organization and appeal a wide area of denials, which was done by one of the home health care national programs, they can just take us one by one and just deny.

Mr. TAUKE. Thank you very much.

Mr. SMITH. Thank you, Mr. Chairman, and I do not think there could be a clearer consensus from this panel that the interpretation of independent care and the too restrictive criteria is causing a very real and vexing problem for our seniors, and causing a great deal of pain and injury to them.

And, it would appear from what you are saying that it is bad and getting worse, if I hear you correctly. As a matter of fact, I understand that the Senate version of the budget included a suggestion for a copayment or a payment of sorts for 20 or more days of home health care. Thankfully, the House version that I supported did not have that.

Mr. TAUKE. If I may interject, why should home health care be the only part A Medicare service that does not have a copayment?

Mr. MAROSY. Well, I think the very basic—the very idea that there should be an incentive for these patients to pay a copayment is ridiculous because, first of all, it is disincentive to be using a less costly form of care.

The cost of collecting this copayment will exceed the amount of the copayment. There will be a net increase in cost to the Medicare program. Two very basic reasons where it does not make sense, and I would think we would want to encourage home health care, and for that reason, it should be excluded as a service with a copayment.

Mr. KAUFFMAN. I would like to say something. You know, one of the things—we talk about alternatives to home care. The institutionalization. You know, most Medicare patients cannot get into an institution anyhow and have it paid by Medicare.

So, I really do not think that is even an alternative. I do not know of very many cases that Medicare pays for nursing homes. They are discharged directly from the hospital out into the community. They do not go—now, if you want to say there is going to be institutionalization for a period, 90 days or whatever, that period is so strict that most nursing homes are not set up to handle it.

So, therefore, you are not getting any use or very limited use of any institutional patient paid for by Medicare.

Mr. SMITH. You know, Mr. Marosy, I noted in your testimony, at least in one of your submissions, your attachments here, that you are very critical of the—of what you perceive the policy contradictions in home health care and perhaps the copayment could be one of those contradictions, when we are trying to emphasize a diminished role for institutionalization.

But, you make a point that the rules that we are following now date back to the sixties, and then all of you have been critical of the interpretation of the rules. Certainly, HCFA has provided you with a response in the past. This cannot be the first time this concern has been raised.

What has been their view? I mean, what is their reasoning? Either in written or in oral form have they provided to you as to their reasons for this very strict and exclusionary interpretation of the rules?

Mr. MAROSY. The general answer that is given to the National Association for Home Care, that we are affiliated with, is that there is still a perception within HCFA that somehow the home health agencies are a bloated industry that is not operating efficiently.

Despite information that has been put together by the National Association for Home Care in addition to State assemblies, that perception remains in the Health Care Financing Administration.

A good data base for home health care is still lacking nationally. New Jersey has one of the best data bases for the utilization of home health care in the country, and that is why we are trying to use the data here in New Jersey to support the need for the expansion of the benefits. Chuck, you may have some additional information.

Mr. SAXTON. If you could begin to wrap it up because——

Mr. KAUFFMAN. Not from HCFA, because we do not directly deal with them, but through our fiscal intermediary, discussions from my director of nurses, Tolbert, to them has said, in regards to intermittent care, which used to be interpreted as a daily visit, now intermittent care is not daily.

That the only way we are going to get that changed is to come to you, the legislators. Because that is what HCFA has dictated, and that is it, and I say well, you know, you are letting people die. Do you not care? Well, we cannot do anything about it.

Well, I do not hear your voice, and I think that the only thing that we can do is through the kind of field hearings is bring the voice of the industry and yes, I think people are dying because they are not getting the appropriate care.

Mr. SAXTON. We thank you for bringing us this message this morning, and for spending the morning with us. The points that you have made are very good ones, and certainly appear to be in direct conflict with what Congress intended when it passed this amendment in 1981. So, we thank you all for the very articulate statements, and we will carry your message, as you suggest, back to Washington.

Thank you.

Our next panel is Charles Pierce, James Schuessler, Robert Blom, Russ Heeran, and Glenn Ruskin. Members of the public and the audience, are there people who have come to testify? This is our last panel, and can I get an idea of how many people there are from the audience who would like to say something? One, two, three, four, can we have your names on a piece of paper someplace so we can move right to that?

The gentleman on my right and the gentleman who was on my left have to leave us no later than 1:30 to catch a flight back to Washington. So I would like to move as quickly as possible so that we can have not only the benefit if this panel, but the benefit of the four or five people who are here in the audience that would like to testify as well.

So, I am going to remind you at 4½ minutes and ask you to wrap up shortly thereafter.

Charlie, you want to proceed? Would you state your name and your position for the record?

STATEMENT OF CHARLES F. PIERCE, DEPUTY COMMISSIONER, NEW JERSEY STATE DEPARTMENT OF HEALTH, TRENTON, NJ

Mr. PIERCE. Congressman Saxton, and Congressman Tauke, and absent Congressman Smith, I am Charles Pierce, Deputy Commissioner from the Department of Health.

I am delighted that you have asked us to come and testify before your panel on a critical set of issues. I have submitted my testimony and copies are with your staff.

Let me just try to highlight the key points. The assignment that I was given was to speak on two separate issues; one was to contrast the New Jersey DRG system which pays hospitals with the national PPS [prospective payment system] which is the way the Federal Government pays hospitals in States other than New Jersey.

The second assignment was to give you a brief overview of some of the alternative health care services and how they have been processed by the Department of Health.

Back to HCFA and its PPS program in contrast to our DRG program. The major similarity is that both programs set a price for an illness or an injury, and this is essentially like a product, called the DRG, diagnostic related group, and the hospital is paid for the patient that is in that particular group and the payment is set in advance. It is a prospective payment.

Now, the superiority of this approach, which was initially developed in New Jersey, then taken over by the Federal Government, I believe, is so strong that it is really no longer an argument or a debate. Nobody is talking about going back to a per diem.

What they are talking about are refinements within the DRG system, and we certainly look forward to further research that might take us along those lines.

I would like to take one quick note, which is not very strongly expressed in my comments, but it is one that you showed some interest in, and that is the whole subject of quality.

In terms of quality, both the New Jersey Department of Health, the PSRO's, and the Federal Government have done a number of studies; using all the indices that we have, we can find no diminution of quality in the hospital services rendered in the State, and I understand in other States as well.

I think the issue of quality will long remain with us and well it should. But, I want to give you just an interesting footnote. About a year and a half ago, the Robert Wood Johnson Foundation gave a very large grant to MIT and Harvard to study the New Jersey DRG system along three lines: financial impact, organizational impact, quality.

Last month, we got a report from the professor who was doing the study on organizational approaches. He told us that, and after they started their study, they came to New Jersey to look into the problem on quality. They went to various physicians, physician groups, looked for documentation and could find nothing that led them to any conclusions that there was a problem with quality and the study was never done.

Now, I would like to pass on to the other, probably more important point, and that is the differences between the New Jersey system and the Federal system of PPS. In New Jersey, our system sets rates for all payers. There is equity among payers.

In the national system, it is only set for the Medicare beneficiaries. That means there can be, and is, cost-shifting for the private payers. It is Medicare essentially looking out for the Medicare trust fund.

In New Jersey, we think that the benefit is, one, that the Blue Cross patients are protected, and, second, there is a whole impact on the hospitals to be as efficient because there is no ability to pass it on to someone else.

The second major difference is that our system provides payments for uncompensated care. That is for those folks who either become bad debts or charity care, the hospitals are reimbursed for those costs.

I am not sure where Dr. Alessi got his data on 15 to 20 hospitals that might be in financial trouble. That is a number that is similar to one we have used in the past and said without uncompensated care, 15 to 20 inner-city hospitals would very quickly become in very serious financial difficulty. They have no way to pay for the medical indigent.

The third very major difference is our system also pays for outpatient care, and the Federal system does not. It is strictly what happens to the patient on the inpatient side.

Now, in New Jersey, this, we believe, is the greatest advantage because uncompensated care is also paid on the outpatient side. So, the hospital can be just as efficient and have just as much incentive to go to the outpatient side as the inpatient side. That is not the case under the Federal system.

Again, I would like to add just a footnote, the Federal Government did renew our 3-year waiver on the inpatient side only. They have denied it on the outpatient side. Wednesday, we will be in court arguing our case. We have been unsuccessful in negotiating it through the system, and if we lose in court on Wednesday, we will face a major problem of how we pay for uncompensated care on the outpatient side.

The likely short-term response would be to create an uncompensated care pool and essentially have to tax the private payers to make up the difference, and Blue Cross would be one of the major places you would see that increase.

Those, essentially, are the three major dissimilarities. If I still have a few minutes, I will go to the other assignment.

Mr. SAXTON. You are at 4½ minutes.

Mr. PIERCE. OK. Long-term care, home health agencies, which was very eloquently spoken to and I need not go into that at all, except to say the New Jersey Department of Health is moved from saying one agency to an area, better we have limited competition, and as the gentleman to my right was one of the first recipients of that change in policy, where we sat in the same geographical area, it is better probably to have more than one.

We have seen the beneficial results, not with any impact on price, but impact on hours, hours that certainly have been extended in the range of services expended.

If, later on, the committee would like me to go in to just a little detail on the long-term care side, I would be delighted to do that.

Thank you.

[The prepared statement of Mr. Pierce follows:]

PREPARED STATEMENT OF CHARLES F. PIERCE, DEPUTY COMMISSIONER, N.J. DEPARTMENT OF HEALTH

Good morning.

Congressman Saxton, members of the committee, I am Charles Pierce, Deputy Commissioner of Health of the New Jersey State Department of Health.

I am pleased to be here today to describe New Jersey's experience in providing health care to the elderly.

As you know, New Jersey is one of the states in the country with a waiver granting it permission to have its own prospective payment system.

I have been asked by Congressman Saxton to focus my discussion on the differences between the national Prospective Payment System and our own Diagnostic Related Groups or DRG's, and then to discuss the effects our DRG system has had on post-discharge services in the state.

In 1976, the New Jersey State Department of Health was awarded a contract from the Health Care Financing Administration (HDFA), then the Social Security Administration, to develop a system of prospective payment of hospitals based upon Diagnosis Related Groups (DRG's). New Jersey's DRG system evolved over the next few years and was implemented by 26 hospitals in 1980, 35 in 1981 and 37 in 1982. The system is fairly complex. Hospital patients are billed an average set rate based upon their diagnosis and other medical conditions. If hospitals can deliver quality care for under the average rate, they keep the difference and vice versa. Uncompensated care is shared by all payers. Hospital rates are set in advance from information supplied to the Department of Health and are a blend of a standard for one of three peer groups—teaching, minor teaching and non-teaching—and the hospital's own costs. The rates also include indirect financial elements such as capital costs and overhead. There are liberal appeal mechanisms for hospital rates, medical technology, medical practice changes and individual patient bills.

The value of the system is fourfold: First, the allocation of resources is equitable and based upon specific products. A hospital's reimbursement is closely tied to the clinical characteristics and volume of the patients it treats.

Second, the resources can be used more effecitively by increasing efficient clinical and financial management. Hospitals can and have responded to the system by instituting and maintaining dialogue between all departments as a means of identifying and embarking on cost-saving programs while maintaining quality care.

Third, there is equity across third-party payers. All payers pay a portion of indigent care costs, which eliminates high differentials in premiums between insurance companies.

Fourth, hospitals are covered for the cost of providing care of indigent patients. They can now concentrate on providing quality medical care to all patients regardless of socio-economic status.

The DRG system differes from the national prospective payment system in several key ways. First, the national prospective payment system covers Medicare only while the New Jersey system covers all payers. The inclusion of all payers in the system enhances the incentives for hospital administrators and meidcal staff to perform efficiently since cost shifting is eliminated.

Secondly, the New Jersey system includes uncompensated care while the national system doesn't. Thus, in New Jersey adequate access to medical care is assured for the medically needy, those too poor to afford their own medical coverge but whose financial situation is not dismal enough to make them eligible for Medicare.

The third major difference is that the New Jersey system covers outpatient care while the PPS doesn't. This vital to the health of the system because it encourages hosptial to treat people on an out-patent basis when medically possible. The PPS system has not such incentive.

In fact New Jersey is at present going through the court system to keep our outpatient waiver.

EFFECTS ON PATIENTS

One issue that has been brought up is whether or not quality of care suffers under New Jersey's DRG system. A preliminary assessment by Metropolitan Peer Review Organization (MetPRO) which covered three counties and 237,000 patient records, showed that there was not problem with early discharge, readmission or mortality, particularly among the over 65 population under the DRG system.

Anecdotal stories surface occasionally, and several have been investigated by the department. Indications are that these incident would have occurred no matter what hospital payment system was in effect. The DRG system implementation, I believe, has served to make the public and the industry more aware of incident and more willing to question health care practice.

In general we believe that prompt and appropriate discharge of patients is a goal for everyone.

Although it may seem that the DRG system and the department dictate when a patient should be discharged, this is not so. Physicians and only physicians can decide when to discharge a patient. There is a system called P.R.O.—Peer Review Organization—which monitors the appropriateness of discharge for each patient. However, DRG's have educated hospitals an doctors on the most efficient and cost-effective use of hospitals to provide the highest quality care, and both hopsitals and the medical community have come to realize that convalescence can best be completed in an alternate setting.

Therefore, the DRG system, and the national PPS system, have created the need for more sophisticated care delivered after the hospital stay—either in the home, or in long-term care facilities. In New Jersey, the Department of Health has responded to the need for most post/hospital care in several ways, keeping in mind that we have a special population—the elderly. Our Commissioner has noted that the "graying" of New Jersey is occurring at a noticeable rate. The number of elderly persons is expected to increase by 28% in the next decade, and by the year 2000, the total number of elderly people in New Jersey is expected to comprise 15% of the population, as compared to 12% in 1980.

Statistics indicate that by 2000 our old-old population, aged 75 and older, will have increased by 88%, which means they're increasing in number six times faster than the working age population. Therefore, the state is reponding to the need for more long-term care services.

We now have 36,506 long-term care beds in the state and by 1988 we expect to have 45,000 long-term care beds, which we estimate is sufficient to meet the needs of our population.

In 1984, we approved over 5,300 new beds, almost 500 of which were in Ocean County. Two hundred and forty beds actually came on-line in Ocean in 1984.

In addition, we have also developed a new philosophy concerning Home Health Agencies. In the past there was usually only one Home Health Agency to serve an area, however we now have a policy of promoting limited competition and have licensed 3 agencies to serve Burlington County in 1984 for a total of 6 in that county, and 2 in Ocean County for a total of 3. We calculate that each agency will do a minimum of 5,000 home visits a year for a total of 45,000 visits. Within the state as a whole we increased the number of health agencies from 51 to 64 in 1984.

The question has been raised: Why not license as many agencies as want to open?

States that have done this have found that the cost of Home Health care, rather than going down as a result of the competition, has gone up. When an agency opens, it has certain operating costs which are basic and must be passed on to the patient. More agencies mean fewer patients per agency which means that operating costs are divided among fewer payers. Therefore, under a totally non-regulated system, the cost per patient rises.

The best choise is limited competition through a certificate of need process.

Conversely, a system with only one provider, while keeping costs down, seriously limits access and does nothing to ensure quality.

I've already talked about increasing the number of nursing home beds and home health agencies. The third area the department is active in is encouraging alternate care facilities such as continuing care retirement communities which provide everything from residential housing to full long-term nursing care. In these, a person may enter the community as early as age 50 after paying a lump sum entrance fee and then stay in the community for the rest of his or her life, moving from one level of care to another.

Another alternative the department is encouraging is residential health care facilities. These provide personal care services and some health care services to ambulatory residents in a less restrictive and less costly environment than nursing homes. To promote this alternative, the department has, since 1982, required all nursing homes approved through the CN process to also offer a residential health care component. Approximately 3,000 of these much needed beds have been approved since that time.

Congressman Saxton has asked me to address the issue of cost. Cost to a private patient in the long-term care facility is largely a function of the market place. No one regulates it. However, about ⅔ of the patients in nursing homes are on Medicaid, and the Department of Human Services' budget dictates Medicaid payment rates. Based on this budget, and with a contract from Human Services, the Department of Health sets Medicaid nursing rates. Therefore, private patients who pay what the market will bear may be subsidizing a good portion of the nursing homes' Medicaid patients.

One of the issues you asked me to address was whether patients were having access problems. One evidence indicates that virtually all areas of the state have enough long-term care beds and home health services to accommodate patients.

Some access problems may occur because when patients are in nursing homes, the family may want them located in facilities close to them. We sympathize with this issue, but, there are enough beds in the state to accommodate those who need them.

The other access problem is money. The Department of Health (nor any other state agency for that matter) cannot regulate what a nursing home can charge its private patient.

The department also recognizes that most people would prefer to be cared for at home. A survey done three or four years ago indicated that 86% of all nursing home patients didn't want to be there. But, it costs approximately the same for two hours of home nursing care as it does for a day in a nursing home. So, again, economics play a tremendous part.

I hope I have provided some information on the issues in New Jersey. I would be happy to answer any questions you might have.

Mr. SAXTON. Thank you, Mr. Pierce.

Mr. Jim Schuessler from the Community Memorial Hospital is someone who certainly plays a very direct role in the lives of the people of Ocean County, and we appreciate your being here and we are happy to have you here to testify on this important subject.

Mr. SCHUESSLER. Thank you, sir.

STATEMENT OF JAMES SCHUESSLER, PRESIDENT AND CHIEF EXECUTIVE OFFICER, COMMUNITY MEMORIAL HOSPITAL, TOMS RIVER, NJ

Mr. SCHUESSLER. Members of the congressional delegation and, of course, Mr. Chairman, I would like to extend some personnel greetings, first, to Jim, one of his greatest fans and beneficiaries of his activities on behalf of our community was admitted to our hospital this morning, Naomi Rice, who is doing fine. She is the president of CARE Manchester, and a terrific program in cooperation with our hospital.

My notes say good morning. It is now good afternoon. My name is Jim Schuessler and I am the president and chief executive officer of Community Memorial Health Services Corp. in Toms River.

The organization I represent consists of a parent holding corporation, a not-for-profit hospital operating corporation, a public foundation, and Center State Health Group, which is a diversified not-for-profit corporation, whose holdings include a 220-bed Country Manor Nursing Home.

Community Memorial is the flagship of our family organization. It is a 460-bed regional health care center here in Toms River, and perhaps most importantly to our discussions today, 65 to 70 percent of our patient-days are delivered to Medicare beneficiaries.

I am unaware of any other hospital in this region of the country that can match that statistic. Among our many programs having the direct focus on the elderly and their special health care needs is a hospital-based Medicare certified home care department, which Mr. Pierce referred to a moment ago.

I am appreciative for the opportunity to present the position of our hospital on some of the topics before the select committee, and I congratulate the committee for its honest and sincere inquiry into the issues facing our country in dealing with the growing health care delivery problems of an increasingly aged population. In many ways, the population of this area in Ocean County and that population's impact on the health care delivery systems foretells what the rest of this country will be like in the future, as all of our citizens live longer and as those older Americans become a larger and larger percentage of our population.

Life for all health care providers has changed dramatically in recent years, perhaps in no area as much as New Jersey. State and Federal initiatives have focused on the high cost of delivering high quality institutional health care, and on mechanisms designed to reduce increases in those costs. All of us as citizens and taxpayers have a stake in the success of these many initiatives. But, likewise, all of us, as potential and, in fact, inevitable patients, have a stake in ensuring that the necessary initiatives to contain costs do not compromise quality of care or the dignity and independence of the ill and the elderly.

I am sure from Mr. Pierce's comments that this body appreciates that my hospital, like every other hospital in New Jersey, does not operate under the Federal PPS system by which Medicare reimburses most hospitals in this country for the care of Medicare beneficiaries. The State of New Jersey has been granted a waiver to operate its own DRG-based reimbursement system. This all payer system began some years ago, as an early model of a yet to be developed Federal system which, of course, now has been mandated by Congress. According to information supplied by the Department of Health in New Jersey, in waiver applications, the New Jersey system will result in Community Memorial Hospital receiving nearly $10 million less in Medicare funds during the period 1985 to 1987 than it would have received under the Federal PPS system.

The millions of dollars which Congress, in designing the PPS system, intended to be allocated for the care of the Medicare patients in this one hospital are being consumed by a complicated reimbursement system that is baffling even to some of its own architects.

Notwithstanding Community Memorial's problems with the Medicare waiver, we share many experiences with hospitals around our

State and around our country relative to the elderly and the various cost-containment initiatives.

Patients discharged from hospitals today have greater need for post-acute care than ever before. The reasons for this, I think, are fivefold, or the indications, in any case.

First of all, contrary to testimony that you have heard earlier, my information leads me to believe that readmission rates are increasing. Patients are discharged earlier in the course of their recovery without any question, and medicine is providing for the survival of victims of accidents and disease who, in earlier years, did not survive. Therefore, the numbers of disabled and chronically ill persons is on the rise as well.

It is a fact that the average length of stay for patients in home care programs is increasing, and as these programs care for ever more acutely ill patients, and, finally, physicians undoubtedly feel inappropriately pressured by the PRO system to hurry patients out of the hospital.

Accordingly, our hospital strongly recommends enactment of Senate bill 778, and House bill 2371, which would redefine intermittent care at home and would authorize increasing frequency of high-technology home services to those patients.

Elderly patients, as well as other patients in Ocean County, benefit from several important programs and resources unique to our area. Both our hospital and the Ocean County Health Department operate busy certified home health agencies, with a long list of services that are available.

There are many quality nursing homes in Ocean County, including our Country Manor, but more are needed. Country Manor is unique with its coma program, however, wherein comprehensive care is provided to long-term coma patients in a program that we attract patients from all over the country to.

There is a need for medical day care for adults in Ocean County, and residential health care programs and facilities are practically nonexistent.

The following recommendations are made by our hospital to support containment of health care costs and to promote high quality care. I commend them for your most serious consideration, and they are nine.

First, mandate increased coverage for home care in major medical plans.

Second, require increased emphasis on home care coverage and other cost-saving treatment modalities in employer-supplied health insurance programs.

Third, create significant tax incentives to encourage families to care for the long-term needs of chronically ill family members at home, a change that will generate huge savings to the system.

Fourth, establish tax exemption of IRA funds utilized to finance long-term care.

Fifth, encourage programs which permit older Americans to utilize equity in their homes to finance home care without necessitating the selling of those homes during their lifetime.

Sixth, develop a prospective payment system for Medicare certified home care, much as has been done for inpatient care in hospitals.

Seventh, mandate a full and comprehensive home-care program as a dramatic cost-control mechanism for the VA system, as addressed earlier in today's program.

Eighth, support extension of the current 3-year experimental program now scheduled to expire in September 1986, which provides hospice benefits under Medicare, allowing terminally ill beneficiaries to be cared for at home.

A program, I might add, that has been phenomenally successful here in Ocean County.

Ninth, reevaluate the PRO Program. Most especially in terms of re-establishing review of care on a concurrent, rather than retrospective, basis.

You have heard testimony, I think, from every single provider on each of the panels this morning as to the totally inappropriate mechanism by which care that is delivered in good faith by various providers, whether they be institutions or physicians, and finding out months after the fact that the expenditure of those resources is not going to be reimbursed. Terrible situation.

Mr. SAXTON. Let me ask you to summarize.

Mr. SCHUESSLER. I am going to do that.

Mr. SAXTON. Thank you.

Mr. SCHUESSLER. I want to thank you today on behalf of our patients, not so much the hospital, but the people that we serve, for your concerns for their future, and I invite each of you to visit our hospital, our nursing home, and our other facilities to see for yourself the successful efforts of over 2,300 employees working here in Ocean County dedicated to that future.

And, in closing, I would like very sincerely to commend this congressional panel on their insight into the problems facing the provider community in these rapidly changing times. I was very refreshed to hear the particularly incisive questions that were directed to the representative from HCFA, and I hope that that tone of inquiry will continue.

Thank you.

[The prepared statement of Mr. Schuessler follows:]

PREPARED STATEMENT OF JAMES SCHUESSLER, PRESIDENT AND CHIEF EXECUTIVE OFFICER, COMMUNITY MEMORIAL HOSPITAL HEALTH SERVICES CORP., TOMS RIVER, NJ

Good morning. My name is James Schuessler, and I am the President and Chief Executive Officer of Community Memorial Hospital Health Services Corporation, Toms River, New Jersey. The organization I represent consists of a parent holding corporation, a not-for-profit hospital operating corporation, a public foundation, and Center State Health Group—a diversified, not-for-profit corporation whose holdings include the 220 bed Country Manor Nursing Home.

Community Memorial Hospital, the flagship of our family of organizations, is a 460 bed regional health care center in Toms River. 65-70 percent of our patient days are delivered to Medicare beneficiaries. Among our many programs having a direct focus on the elderly and their special health care needs is a hospital-based, Medicare-certified, home care department.

I am appreciative of the opportunity to present the position of Community Memorial on some of the topics before the Select Committee, and I congratulate the Committee for its honest and sincere inquiry into the issues facing our county in dealing with the growing health care delivery problems of an increasingly aged population. In many ways, the population of this area in Ocean County, and that population's impact on the health delivery system, foretells what the rest of our country will be like in the future, as our citizens live longer, and as those older Americans become a larger and larger percentage of our population.

Life for all health care providers has changed dramatically in recent years, perhaps in no area so much as in New Jersey. State and Federal institutions have focused on the high cost of delivering high quality institutional health care and on mechanisms designed to reduce increases in those costs. All of us, as citizens and taxpayors, have a stake in the success of these many initiatives. But likewise, all of us, as potential and inevitable patients, have a stake in ensuring that the necessary initiatives to contain costs do not compromise quality of care or the dignity and independence of the ill and the elderly.

I am sure that this body appreciates that my hospital does not operate under the Federal PPS system, by which Medicare reimburses most hospitals in this country for the care of Medicare beneficiaries. The State of New Jersey has been granted a waiver to operate its own DRG-based reimbursement system. This all-payor system began some years ago as an early model of the yet-to-be-developed federal system, which has now been mandated by Congress. According to information supplied by the New Jersey Department of Health in its waiver application, the New Jersey system will result in Community Memorial Hospital receiving nearly $10 million less in Medicare dollars during the period 1985–1987, then it would have received under the Federal PPS system. The millions of dollars which the Congress, in designing the PPS system intended to be allocated for care of Medicare patients in this hospital, are being consumed by a complex reimbursement system that is baffling even to some of its own architects.

Notwithstanding Community Memorial's problems with the "Medicare waiver," we share many experiences with hospitals around our state and around our country relative to the elderly and various cost containment initiatives.

Patients discharged from hospitals today have greater need for post-acute care than ever before:

1. Readmission rates are increasing;
2. Patients are discharged earlier in the course of their recovery;
3. Medicine is providing survival for disease and accident victims who in earlier years did not survive—therefore, the numbers of disabled an chronically ill persons is on the rise;
4. The Average Length of Stay (ALOS) for patients in home care programs is increasing, as these programs care for even more acutely ill patients;
5. Physicians feel inappropriately pressured by the PRO system to hurry patients out of the hospital.

Accordingly, our hospital strongly recommends enactment of Senate Bill 778 and House Bill 2371 which would redefine intermittent care at home and would authorize increasing the frequency of high tech home health services.

Elderly patients (as well as all other patients) in Ocean County benefit from several important programs and resources. Both our hospital and the Ocean County Health Department operate busy Medicare-certified home health agencies. Community Memorial's program includes: skilled nursing services; physical, occupational, and speech therapists; medical social work; home health aides; nutritional services; "high tech" services including perinternal and enternal nutrition, IV antibiotic therapy, chemotherapy. CMH even has patients maintained at home on ventilators.

There are many quality nursing homes in Ocean County, including our Country Manor. And more are needed. Country Manor is unique with its Coma Program, however, wherein comprehensive care is provided to long term coma patients.

There is a need for adult medical day care and residential health care programs and facilities in Ocean County.

The following recommendations are made by our hospital to support containment of health care costs and to promote high quality care. I commend them to your most serious consideration.

1. Mandate increased coverage of home care in major medical plans.
2. Require increased emphasis on home health care coverage and other cost-saving treatment modalities in employer-supplied health insurance programs.
3. Create significant tax incentives to encourage families to care for the long term needs of chronically ill family members at home, a change that will generate huge savings to the system.
4. Establish tax exemption of IRA funds utilized to finance long term care.
5. Encourage programs which permit older Americans to utilize equity in their homes to finance home care without necessitating selling those homes during their lifetime.
6. Develop a prospective payment system for Medicare-certified home care.
7. Mandate a full and comprehensive home care program as a dramatic cost control mechanism for the VA system.

8. Support extension of the current three year experimental program now scheduled to end in September 1986 which provides hospice benefits under Medicare, allowing terminally ill beneficiaries to be cared for at home.

9. Reevaluate the PRO program, most especially in terms of re-establishing review of care on a concurrent, rather than retrospective, basis.

I thank you on behalf of our patients for your interest and concern for their future. And I invite you to visit our hospital, our nursing home, and our other facilities to see for yourself the successful efforts of over 2300 employees dedicated to the future.

Mr. **Saxton**. Thank you.

Mr. Russ Heeran from the American Association of Retired Persons. You are on, sir.

STATEMENT OF RUSSEL HEERAN, NATIONAL LEGISLATIVE COUNCIL, AMERICAN ASSOCIATION OF RETIRED PERSONS, BERKELEY TOWNSHIP, NJ

Mr. **Heeran**. Mr. Chairman, members of the committee, my name is Russell Heeran. I am a member of the national legislative counsel of the American Association of Retired Persons. On behalf of the 19 million members of AARP, I want to thank you for this opportunity to state the association's views of the Medicare DRG prospective payment system and the need for the alternatives to industrial institutional care.

I have my full testimony, which has been given, and, hopefully, will be in the record. Before I start my report, I have here also a statement on home health care from the State legislative committee of AARP.

When we talk about home health care in New Jersey, we expect the entire gamut of health care in the home as expressed by the previous panel this morning.

Under DRG's, hospitals have the incentive to perform fewer services and to get Medicare patients out of the hospital as soon as possible in order to maximize their profits. Moreover, new administrative rules and policies under DRG's limit Medicare patients' utilization of certain kinds of care and medical procedures.

For example, HCFA requires PRO's to reduce identified procedures by specific amounts. These procedures vary from State to State. In addition, beneficiaries are placed in greater financial jeopardy for services now deemed to be noncovered and for services moved from the inpatient to the outpatient setting, where greater cost sharing is required.

The administration and the Congress must understand that these incentives are hurting Medicare patients. Although anecdotal evidence is currently available to describe the effects of DRG's on patients, such evidence continues to mount. HCFA policy decisions on other issues are having an adverse impact on Medicare patients under the DRG system.

Access to skilled nursing home care and home health care are cases in point. In hopes of encouraging more skilled nursing facilities to become involved in Medicare, Congress provided a waiver of liability for cushioning SNF against wrong decisions about whether patients are covered for SNF care.

It is a presumption that SNF acts in good faith if incorrect coverage decisions represent 5 percent or less of the provider's Medicare caseload. If SNF meets the presumption, then Medicare will pay for the uncovered services.

In a recent notice of proposed rule, HCFA eliminates the waivers of liability by eliminating the presumption of good faith. The result of this change will be to further discourage SNF from taking Medicare patients, thus making it even more difficult for proposed acute care patients to get the skilled nursing care that are needed.

The elimination of the waiver of liability affects home health care providers, too. In addition, other policies tend to foreclose access to home care. To qualify for home health care services under Medicare, a patient must be homebound and in need of intermittent care. HCFA has so restricted the definition of homebound and intermittent care, however, that even the sicker patients coming out of the hospital under the DRG system are having trouble qualifying for postacute care services at home.

The current postacute care situation for Medicare patients can be compared to the deinstitutionalization of mental hospital patients in the seventies. In the seventies, it was considered good public policy to close down mental hospitals and serve those patients in the community.

The only problem was that we neglected to establish a community based mental health care system to serve them. As a result, the lucky deinstitutionalized patients ended up in nursing homes under Medicaid. The unlucky ones ended up in the street or in the criminal justice system.

The association will not sit idle while Medicare patients are forced out of hospitals, still needing care, without any place to go. It is generally—it is becoming generally recognized that the greatest deficiency in the present health care system is the lack of comprehensive financing and delivery mechanisms for caring for those with chronic illnesses or disabilities.

Unfortunately, the incremental development of the long-term nursing care system has resulted in a haphazard cumbersome and too often ineffective array of benefits that do not meet the needs of an aging population.

The association is strongly committed to developing a LTC Program that provides not just institutional care, but a complete continuum of services, including home health care and community-based services.

I will jump to the seven recommendations.

Mr. SAXTON. OK.

Mr. HEERAN. In order to improve the DRG system and promote the development of community-based alternatives, AARP recommends:

First, the Medicare appeals procedure must be changed to reflect the greatest beneficiary liability under DRG. The changes should include formal hearing records and reported decisions under parts A and B as well as independent caring examiners under part B.

Second, there must be a single national definition of homebound or for intermittent care.

Third, institutional care must be only one benefit in a case managed system of long-term care that also provides inhome and community-based services.

Fourth, a severity of illness index must be incorporated into the DRG system.

Fifth, PRO's must be allowed the flexibility and given incentives to be innovative in monitoring the quality of care and to experiment with new medical review criteria. Data profiling strategies, decision feedback mechanisms, sufficient training and consumer education ideas.

Sixth, the waiver of liability presumption for part A providers must not be revoked.

Seventh, to validate the numerical reduction in unidentified medical procedures HCFA requires of the PRO's, AARP supports allotting .05 percent of all HI revenues to study small area practice variations and feedback the information to physicians.

Thank you, Mr. Chairman, for letting us voice the views of the American Association of Retired Persons, on this critical area of policy.

[The prepared statement, along with the statement of Home Health Care, submitted by Mr. Heeren follows:]

PREPARED STATEMENT OF RUSSEL HEEREN, NATIONAL LEGISLATIVE COUNSEL, AMERICAN ASSOCIATION OF RETIRED PERSONS, BERKELEY TOWNSHIP, NEW JERSEY

STATEMENT OF THE AMERICAN ASSOCIATION OF RETIRED PERSONS ON THE MEDICARE DRG PROSPECTIVE PAYMENT SYSTEM, JUNE 24, 1985

INTRODUCTION

Good morning, Mr. Chairman, my name is Russell Heeren and I am a member of the National Legislative Council of the American Association of Retired Persons. On behalf of the 19 million members of the AARP, I want to thank you for this opportunity to state the Association's views on the Medicare DRG prospective payment system. The Medicare DRG system is 19 months old and all non-exempt hospitals participating in Medicare have begun the phase-in towards national DRG rates. Thus it is a good time to step back, take a look at what is happening to patients under DRGs, and make necessary adjustments to the system.

My testimony today identifies three areas of concern about the implementation and operation of the DRG system so far: (1) The Health Care Financing Administration's (HCFR) failure to adequately monitor and correct for the economic incentives under DRGs to skimp on quality care; (2) the serious lack of policy coordination and support of DRGs by contemporaneous HCFA policies; and, (3) the need to develop cost effective alterantives to institutional care.

Following the discussion of these points, AARP makes several recommendations to improve the administration of DRGs, including: changes in the Medicare appeals process, improved access and coverage for beneficiaries needing post acute care services, and innovative efforts by peer review organizations (PROs) to monitor and enforce standards for quality care.

HOSPITAL INCENTIVES UNDER DRGS

The DRG prospective payment system has dramatically changed the incentives to hospitals treating Medicare patients. Under the old cost plus system, hospitals were paid for each service provided. The more services provided, the more money the hospital received. Thus, it was in the hospitals interest to provide excessive services and to keep a patient hospitalized as long as possible. Under DRGs, however, those incentives are gone.

Under DRGs, hospitals have the opposite incentives—to perform fewer services and to get Medicare patients out of the hospital as soon as possible in order to maximize their "profit." Moreover, new administration rules and policies under DRGs limit Medicare patients' utilization of certain kinds of care and medical procedures.

For example, HCFA requires PROs to reduce identified procedures (the procedures vary from state to state) by specific amounts.

PROs will be evaluated HCFA based, in part, on how well they meet these numerical reductions. For most parts of the country, however, these numbers are based on little or no evidence that the procedures identified can be safely reduced without precluding access to necessary care.

Another example of a government requirement that places Medicare beneficiaries in jeopardy is HCFA's policy directive permitting hospitals to inform Medicare patients before admission, at admission, or during the hospital stay that certain services may not be covered by Medicare and that the patient is liable for payment if he or she goes forward with the treatment. This directive is a major new loop-hole in Medicare, and will result in greater out-of-pocket costs to beneficiaries.

Thus, the incentives inherent in the DRG system combined with the new rules implementing it, substantially alter Medicare patients' rights under DRGs. This combination of structural incentives and administrative incentives jeopardizes beneficiaries in two ways: (1) there is greater jeopardy to individual health status from skimping on services, and (2) there is greater financial jeopardy for services now deemed to be non-covered and for services moved from the inpatient to the outpatient setting where greater cost sharing is required.

The Administration and the Congress must understand that these incentives are hurting Medicare patients. Although only anecdotal evidence is currently available to describe the effect of DRGs on patients, such evidence continues to mount.

Evidence that DRGs are harming patients—

In February, 1985, the House Select Committee on Aging held a joint hearing with the House Task Force on the Rural Elderly. The subject of the hearing was the quality of care under DRGs. Witnesses testified about problems of early discharge and lack of post acute care services. One witness, a discharge planner for a large hospital in Minneapolis, told about the difficulties she had maintaining hospital care for her sick mother because the small rural hospital claimed her mother's allotted days of care under the DRG had run out. Fortunately, the witness was knowledgable about DRGs and was able to fight the hospital. Unfortunately, not all Medicare beneficiaries or their families are as familiar with the system and therefore, are much more likely to acquiesce in the hospital's decision.

On February 26, 1985, the Senate Special Committee on Aging released a report from the General Accounting Office on the impact of Medicare's new prospective payment system on post hospital care. The report showed that Medicare patients are being discharged "quicker and sicker," too often with no place to go.

The American Association of Retired Persons is also trying to evaluate the scope and breath of the problems affecting patient care under DRGs. The Association has received over 200 letters and numerous telephone calls from Medicare beneficiaries, their children, nurses, and social workers complaining about poor care and premature discharge under DRGs. The story that follows is illustrative of the anxiety and frustration encountered by Medicare beneficiaries and their families under DRG prospective payment system.

A 71 year old Medicare beneficiary in Texas, with an artificial heart valve, wrote about her own unhappy experience. (She is a retired R.N.) She was admitted to the hospital because of a high temperature caused by an upper respiratory infection. Her artificial heart valve was an additional dimension of concern indicating hospitalization.

After being admitted she developed problems breathing and was placed on continuous oxygen and inhalation therapy three times a day. The night of her third day in the hospital inhalation therapy was required for the entire night. In addition, although she was expectorating "thick, purulent matter, tinged with blood," no one at the hospital was concerned enough to investigate.

On the morning of the fourth day in the hospital her doctor announced she was going home. When she protested, he said that the hospital has a new policy and that they now determined how long a Medicare patient could stay. She writes that her doctor was very upset—even "intimidated" by the hospital. He told her not to fight the hospital. She stated her fears about a relapse or dangerous complications, and refused to go home until her temperature was normal for 24 hours.

On the morning of the fifth day, the hospital's head nurse ordered her to go home and threatened, if she did not leave, to move her to a special floor with no heart or lung equipment and minimal nursing care; for such minimal care the patient herself was to be charged $65 per day. She was finally discharged the following morning.

After five weeks of recovering at home, she investigated the new Medicare DRG system and learned, among other things: that the hospital has a medical review board consisting of doctors, nurses, and other hospital personnel, but (1) that, in this case, it is a medical librarian who makes the decisions about how long a patient can stay, and (2) that doctors are pressured to discharge patients as the hospital dictates.

CONTEMPORANEOUS HCFA POLICIES AFFECTING DRGS

HCFA policy decisions on other issues are having an adverse impact on Medicare patients under the DRG system. Apparently, HCFA does not appreciate the power of the incentives under DRGs to discharge patients "quicker and sicker." HCFA is pursuing policies that foreclose increased access to post acute care services instead of fostering it. Access to skilled nursing home care and home health care are cases in point.

Access to skilled nursing home care has long been the forgotten promise of Medicare. For a variety of reasons, skilled nursing facilities (SNF) have not been a reliable benefit for Medicare beneficiaries. In hopes of encouraging more SNFs to become involved in Medicare, Congress provided a mechanism for "cushioning" SNFs against wrong decisions about whether a patient is covered for SNF care. This "cushion" is called the waiver of liability. It is a presumption that a SNF acts in good faith if incorrect coverage decisions represent five percent or less of the providers' Medicare case load. If a SNF meets the presumption, then Medicare will pay for the uncovered services.

In a recent notice of proposed rule, HCFA eliminates the waiver of liability by eliminating the presumption of good faith. The result of this change will be to further discourage SNFs from taking Medicare patients, thus making it even more difficult for post acute care patients to get the skilled care that they need.

The elimination of the waiver of liability affects home health care providers too. Beyond the waiver problem, however, home health care providers face other HCFA policies that tend to foreclose access to home care. To qualify for home health services under Medicare a patient must be "homebound" and in need of only "intermittent" care. HCFA has so restricted the definitions of "homebound" and "intermittent" care, however, that even the sicker patients coming out of hospitals under the DRG system are having trouble qualifying for post acute care services at home.

These conflicting, contemporaneous policy directions reduce the availability of post acute care services necessary to accommodate medicare patients under DRGs. Hence, Medicare patients are being discharged from hospitals into a no-care zone.

The current post acute care situation for Medicare patients can be compared to the deinstitutionalization of mental hospital patients in the 1970s. It was considered good public policy to close down mental hospitals and serve those patients in the community. The only problem was that we neglected to establish a community based mental health care system to serve them. As a result, the lucky deinstitutionalized patients ended up in nursing homes under Medicaid; the unlucky ones ended up on the streets or in the criminal justice system. The Association will not sit idle while Medicare patients are forced out of hospitals still needing care and without any place to go. If policy makers cannot provide the post acute care services necessary under the incentives of the DRG prospective payment system, then it is time to change the system.

THE NEED FOR ALTERNATIVES TO INSTITUTIONAL CARE

It is becoming generally recognized that the greatest deficiency in the present health care system is the lack of comprehensive financing and delivery mechanisms for caring for those with chronic illness or disability. Unfortunately, the incremental development of the existing long term care (LTC) system has resulted in a haphazard, cumbersome, and too often ineffective array of benefits that do not meet the needs of an aging population. The Association is strongly committed to developing a LTC program that provides not just institutional care, but a complete continuum of services. Services such as homemaker/chore, home health, and nutrition services are often more effective than institutional care in meeting the needs of chronic care patients.

The failure to develop a serious, comprehensive effort to link and coordinate the management of in-home services, community services, special living arrangements, nursing home care, and other forms of long term services within the community, has resulted in a long term care system that provides only acute and episodic care and institutionally-based services when other services would have been more effective and less costly. The risk of not developing these linkages is that society will be unable to respond to needs it knows are looming in the future, or to control the costs of maintaining a viable LTC program faced with increasing demand and dwindling resources.

Policymakers have been reluctant to approach the difficult issues of linking medical and non-medical services to meet the needs of chronic care patients. In view of the demand for services, however, public sector efforts, to establish these linkages must become a national priority and private sector financing of LTC services must be encouraged to assure that adequate resources are available to develop a comprehensive community-based system of long term care.

In the public sector, establishing the link between health services and the broader range of social and personal services requires changing existing policies. To achieve this link, it is necessary to alter the financial incentives for institutional care that currently exists. By providing institutional care as but one benefit in a case-managed system of long-term care and by providing financial incentives through a prospectively determined amount of funds, in-home and community-based care becomes a more feasible and desirable alternative to institutionalization.

The task of creating the necessary "structural bridges" between medical care and health related services involves building new relationships between government programs and among different levels of government. Crucial to this task is developing ways to creatively use funds available through Title XX, the Older Americans Act, and other federal, state, or local programs. Within broad federal guidelines, states should be free to allocate such funds as needed to develop efficient administrative and delivery alternatives.

In private sector side, the growth in the functionally dependent population requires that private sector LTC financing mechanisms be developed and offered to the public. Such financing strategies as Social Health Maintenance Organizations, Home Equity Conversion and private LTC insurance must contribute to the long term care financing solution.

AARP RECOMMENDATIONS FOR STRENGTHENING THE DRG SYSTEM

AARP has always believed that it is possible to contain health care costs and still provide high quality health care. We continue those beliefs. We are deeply concerned, however, that there has not been an adequate effort by HCFA to properly monitor and administer the system and coordinate contemporaneous policies that appreciate the problematic incentives created by the DRG system. This must change. AARP therefore offers the following recommendations:

1. If the Congress freezes DRG rates at 1985 levels, it should also freeze the transition to the national DRG rates.

Freezing the transition to the national DRG rates is necessary to help protect those hospitals that will be "losers" under the national rates. If the transition to national rates proceeds in spite of the freeze then the "loser" hospitals will have even greater problems which, in turn, will affect patient care. Moreover, failure to halt the transition in light of the freeze would foster a two tier health care system with Medicare beneficiaries relegated to the lower tier.

2. The Medicare appeals procedures must be changed to reflect the greater beneficiary liability under DRGs. The changes should include formal hearing records and reported decisions under Parts A and B as well as independent hearing examiners under Part B.

3. There must be a single national definition for "homebound" and for "intermittent" care. AARP favors either Senator Heinz's Home Care Protection Act, S. 778 or H.R. 2371, sponsored by Congressman Waxman.

4. Existing policies must be changed to establish a link between health services and the broader range of social and personal care services. Institutional care must be only one benefit in a case-managed system of long-term care that also provides in-home and community-based services.

5. AARP has long supported a severity of illness index to help adjust hospital payments to reflect high cost patients. In the absence of such an index, AARP is extremely cautious about arbitrary cuts in the allowance for indirect medicare education costs. The indirect medical education costs act somewhat as a proxy for a number of factors, such as severity, which may legitimately increase costs in teaching hospitals.

6. AARP believes that HCFA must reevaluate its approach to quality of care issues through the PROs. PROs must be allowed the flexibility and given incentive to be innovative—to experiment with new medical review criteria, data profiling strategies, physician feedback mechanisms, physician training, and consumer education ideas.

7. The waiver of liability presumption for Part A providers must not be revoked.

8. To validate the numerical reduction in identified medical procedures HCFA requires of the PROs, AARP supports allocating 0.5 percent of HI revenues to study small area practice variations and feedback the information to physicians.

Thank you again, Mr. Chairman, for this opportunity to share the views of the American Association of Retired Persons on this critical area of policy.

STATEMENT OF HOME HEALTH CARE

In response to a recent questionnaire asking for priorities in importance on issues affecting the elderly, members of AARP in New Jersey voted as their top priority to continue the effort to control health care costs, and to expand programs in home health care.

Historically, the health care delivery system has emphasized financial support for acute, short term illness, with expectations of complete cure. The health care needs of the elderly, however, frequently do not fall into that category. Seniors need mostly long term care, to be able over time to adapt themselves to limitations that are not necessarily totally curable, such as the effects of a stroke. Hospitalization is usually not needed for this type of care, and nursing home care is frequently prohibitively expensive, or available only under the sometimes humilating documentation needed to qualify for Medicaid. Even there, seniors with Medicaid support have complaints that they are being exploited by unnecessary testing, padding of bills, and drug experimentation in nursing homes.

Home health care, in these circumstances, is an alternative that offers the security of family and familiar surroundings, and provides the best setting in which maximum adjustment to a crippling illness can take place. It needs to be funded on some systematic basis, so that the professional and paraprofessional care that is needed can be made affordable over the long term. The includes not only medical services, but social counseling, friendship support, and so forth.

In a more long term preventive way, private insurance companies need to be encouraged to develop insurance protection, with reasonable premiums, which would pay, at least in part, for long term care in a home setting, especially if it follows catastrophic illness.

All of these concerns are made even more important now that the DRG system of reimbursing hospitals is resulting in shorter hospital stays, and increasing the demand for community based care and supportive services in a post-hospital situation.

Charges in the delivery of health care are occurring so fast in recent years that seniors are losing any sense of security and stability in what to expect. Yet a person's health is a basic condition which determines much about the kind of life an individual has. With seniors spending more of their income on health care than any other group in the population, it is of great importance that their needs ought to be made affordable to them, and their lives made more comfortable and more secure by the development of effective public policy in this field.

THOMAS WEBER,
Chairman, State Legislative Committee, AARP

Mr. SAXTON. Thank you very, very much, Mr. Heeran. We are old friends. We have been together for 10 years, I guess.

Mr. HEERAN. At least.

Mr. SAXTON. We are very pleased to have with us from Congressman Jim Howard's office, and, incidentally, we work closely with Congressman Howard on matters such as this, Mr. Glenn Ruskin, who is the district representative for Mr. Howard.

Glenn, you are on.

STATEMENT OF GLENN RUSKIN, DISTRICT REPRESENTATIVE; ON BEHALF OF HON. JAMES J. HOWARD, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Mr. RUSKIN. Thank you very much, Mr. Chairman, Congressman Smith and Congressman Tauke.

Congressman Howard had to go back to Washington this morning to take care of business with the Public Works Committee, but he has asked me to come here today and give his testimony.

In the interests of time, I am going to try to summarize his testimony.

The gist of the Congressman's comments today had to do with the peer review organization in the State of New Jersey, which is under contract with the Federal Government, and what the Congressman did was distribute a 15-question survey to thousands of Medicare-eligible individuals in the third congressional district.

I think it is important to try to summarize some of the responses that we had as a result of that survey, and I have left copies of the results of the survey with the staff for inclusion in the record.

First, I would like to just say that, again, the PRO is a private corporation under contract with the Federal Government to oversee and reduce hospital admissions and lengths of stay. The PRO regulations were implemented last year by the Health Care Financing Administration, and now Medicare expenses in States and regions around the country are being monitored by PRO doctors.

The Congressman's survey revealed that 75 percent of the 3,182 seniors responding were under a doctor's care for the treatment of a condition requiring regular visits. From this group, 2,398, the following was learned: 75.3 percent are being reimbursed by Medicare for their conditions; 22.8 percent received notice that their treatments were being limited; 15.3 percent received notice that their treatments were no longer eligible.

Of all 3,182 responding, 720 individuals were admitted in the last year to a hospital on an emergency basis. Of these 720, 33.4 percent had at least part of their claim denied, with some having their entire claim denied.

Of the 497 who reported to have a planned hospital admission, 75.6 percent had at least part of their claim denied. Of those who had emergency admissions or planned hospitalizations, 16 percent were subject to PRO review, and 10.6 percent believed they were discharged too soon as a result of the hospital's utilization review committee or the PRO.

Only 8 percent of all respondants took advantage of their right to appeal claim denials. A very high percentage of those seniors under a doctor's care for treatment of a condition reported their medical care would be adversely affected if Medicare payments were eliminated or restricted—72 percent could not afford treatment if their payments were eliminated, and 32 percent said they would not seek treatment at all if payments were eliminated or restricted.

Most seriously of all, five individuals alleged that the death of a friend or family member was related to his or her premature discharge from a hospital. One Monmouth County woman wrote, "Medicare decided my husband could not stay longer in the hospital, had to transfer him to a nursing home, and he died 4 days later. Doctor had no control of keeping him in the hospital."

Outside of doctors believing they have no care or longer control over their patients, they also fear lawsuits.

Judging from the intensity of the opinion from my district, other Members of Congress will soon be hearing from their older constituents. Over 75 percent of all individuals responding to the survey indicated they do not believe it is in their best interests to allow a Medicare's carrier medical stamp with a PRO to have a direct influence on the medical care recommended by the treating physician, the attending physician in a hospital when admitted in an emergency, determining when patients are to be discharged, or determining if part of the patient's hospitalization was necessary.

Mr. Chairman, the elderly must now deal with a medical delivery system that is successfully containing costs, but is not always providing quality care. PRO's were originally intended to contain costs and provide assurances of quality care, but somehow, in the implementation of the PRO regulations, quality has been virtually ignored, and the—all the emphasis placed on cost control.

Second, I think the Congressman wanted also to pass along the need for a VA outpatient clinic here in Ocean County. He has worked closely with you and cosponsored a bill introduced by Congressman Smith, and I believe that that is a very important thing that is needed here in Ocean County, and I know that he would be appreciative of working with you in the future on that.

Thank you very much.

[The prepared statement of Representative Howard follows:]

PREPARED STATEMENT OF HONORABLE JAMES J. HOWARD, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Mr. CHAIRMAN. During the month of May, I distributed a 15-question survey to thousands of Medicare-eligible individuals in the Third Congressional District. The purpose of the questionnaire was to determine the degree to which Medicare cost-cutting measures were affecting the quality of health care provided to senior citizens in my district.

I was first alerted to what seemed to be new problems with Medicare coverage by constituents who had been denied reimbursement as result of a decision by the Peer Review Organization (PRO) in New Jersey. Further research revealed that while many government officials were hailing the budgetary success of the new PRO and other Medicare cost-cutting measures, no one had tried to find out how these measures were affecting the health care of older Americans. In fact, I am told by the staff of your committee that my questionnaire may well be the only large-scale survey to date of the impact of the new rules and regulations.

As a result of the survey, I can state unequivocally that the quality of health care provided to older Americans is suffering under the new initiatives, particularly the new PRO system.

The PRO is a private corporation under contract with the federal government to oversee and reduce hospital admissions and lengths of stay. PRO regulations were implemented last year by the Health Care Finance Administration and now Medicare expenses in states and regions around the country are being monitored by PRO doctors.

My survey revealed that 75 per cent of the 3,182 senior citizens responding were under a doctor's care for the treatment of a condition requiring regular visits. From this group of 2,398, the following was learned: 75.3 per cent are being reimbursed by Medicare for their condition; 22.8 per cent received notice their treatments were being limited; 15.3 per cent received notice their treatments were no longer eligible.

Of all 3,182 responding, 720 individuals were admitted in the last year to a hospital on an emergency basis. Of these 720, 33.4 per cent had at least part of their claim denied, with some having their entire claim denied. Of the 497 who reported to have had a planned hospital admission, 75.6 per cent had at least part of their claim denied.

Of those who had emergency admissions or planned hospitalizations, 16 per cent were subject to PRO review and 10.6 per cent believe they were discharged too soon as a result of the hospital's Utilization Review Committee or the PRO. Only eight per cent of all respondents took advantage of their right to appeal claim denials.

A very high percentage of those senior citizens under a doctor's care for treatment of a condition reported their medical care would be adversely affected if Medicare payments were eliminated or restricted. Seventy-two per cent said they couldn't afford treatment if their payments were eliminated and 32 per cent they wouldn't seek treatment at all if payments were eliminated or restricted.

Most seriously of all, five individuals alleged that the death of a friend or family member was related to his or her premature discharge from a hospital. One Monmouth County woman wrote, "Medicare decided my husband couldn't stay longer in the hospital. Had to transfer him to a nursing home and he died four days later. Doctor had no control of keeping him (in the hospital)."

Doctors believe they are losing control over the care of their patients. They fear lawsuits. Individual hospital utilization review committees are caught in the middle between trying to assure proper care and responding to extraordinary PRO pressure to reduce admissions and lengths of stay.

For instance, the PRO in New Jersey set a goal of cutting hospital admissions statewide by 15,466 over a two-year period. When the PRO denies Medicare reimbursement for all or part of a hospital stay, it is the hospital which must pay. This is a real threat to the solvency of New Jersey hospitals which have been operating under a strict cost containment plan longer than hospitals in most other states.

Judging from the intensity of the opinion from my district, other Members of Congress will soon be hearing from their older constituents. Over 75 per cent of all individuals responding to the survey indicated they do not believe it is in their best interst to allow a Medicare carrier's medical staff or the PRO to have a direct influence on: the medical care recommended by the treating physician; the attending physican in a hospital when admitted in an emergency; determining when patients are to be discharged; or determining if part of the patient's hospitalization was "unnecessary."

Finally, 85 percent of the total responding stated that they do not believe senior citizens seek medical attention more often than necessary because they have Medicare, and 77 per cent said that the elderly often fail to seek medical attention because they are worried about paying bills.

Mr. Chairman, the elderly must now deal with a medical delivery system that is successfully containing costs but is not always providing quality care. PROs were originally intended to contain costs and provide assurances of quality care, but somehow, in the implementation of the PRO regulations, quality has been virtually ignored and all the emphasis placed on cost control.

Certainly, many point to the decline in hospital use as a measure of the success of cost containment efforts in the Medicare program. But simply, the cost burden is only being shifted to other areas—primarily to our nation's retired, who are being told they will carry more of the burden or forgo recommended treatment.

I intend to do all I can to alert Members of Congress to the serious situation existing in our health care system and to bring about reforms. I urge you, as Members of the House Select Committee on Aging, to begin an inquiry into this situation from a national perspective. All parties to the problem must devote full energies to finding a way to successfully bring down medical costs without endangering the health of older Americans.

Mr. Chairman, if you have any questions regarding my survey, my staff assistant Glenn Ruskin will take your questions and I will submit answers for inclusion in the record. I am also submitting for the record a chart summarizing most of our survey findings and a copy of the original questionnaire.

Finally, Mr. Chairman, I want to add a few comments regarding my support for the establishment of a VA outpatient clinic in Ocean County.

The VA currently has under review the 1984 Medical District Program Planning Study (MEDIPPs). MEDIPPs uses a sophisticated computer projection to predict the medical needs of the individual medical districts. Ocean County is part of Medical District IV, which is comprised of New Jersey, Delaware, Maryland and Pennsylvania.

The MEDIPPs draft has identified Ocean County as the area with the greatest projected need in District IV for increased health care for veterans. I am pleased that the draft has been transmitted to VA Administrator Harry Walters from the Chief Medical Director for final approval.

The minimum threshold requirement used by the VA to establish a satellite outpatient health care facility is 21,000 patient visits a year. the projected use for a clinic by 1990 in Ocean County is 52,000 visits a year. In other words, the need is nearly two and one half times greater than the figure used to justify the establishment of a facility.

It is for this reason that I submitted testimony on March 5, 1985, to the House Subcommittee on Hospitals and Health Care urging inclusion of funds in the budget at the earliest possible time to construct an outpatient facility in Ocean County. I have joined with the entire New Jersey Congressional delegation in cosponsoring H.R. 1424, sponsored by Rep. Chris Smith, directing the Administrator of the VA to build this clinic. I have written to Budget Director David Stockman and VA Administrator Harry Walters requesting expeditious approval of necessary funds. Finally, I have received personal assurances of support from Congressman Sonny Montgomery, Chairman of the House Committee on Veterans Affairs.

In short, I remain committed to the establishment of this facility at the earliest possible time. I recognize the fiscal constraints imposed by the intolerable budget deficit the country is now running. We must make every effort to eliminate wasteful government expenditures so that the real needs of our country may be met. However, when a real need such as the Ocean County veterans clinic presents itself, that need must be met.

Responses to Third District Medicare survey

Seventy-five percent of the 3,182 senior citizens responding said they were under a doctor's care for the treatment of a condition requiring regular visits. From this group of 2,398, the following was learned:

75.3% are being reimbursed by Medicare for their condition
22.8% received notice treatments are being limited
15.3% received notice treatments are no longer eligible

Of all 3,182 responding, 720 individuals were admitted in the last year to a hospital on an emergency basis and 497 had a planned admission to a hospital. Medicare denied a high percentage of our respondents at least part of their claims.

Emergency hospital admissions 720 (100%)

Claims denied 241 (33.4%)

Planned hospital admissions 497 (100%)

Claims denied 376 (75.6%)

Of those reporting emergency admissions or planned hospitalizations, 16% were subject to PRO review and 10.6% believe they were discharged too soon as a result of the hospital's Utilization Review Committee or the PRO. Only eight percent of all respondents took advantage of their right to appeal claim denials.

A very high percentage of those senior citizens under a doctor's care for treatment of a condition reported their medical care would be adversely affected if Medicare payments were eliminated or restricted.

Under doctor's care for treatment 2,398 (100%)

Couldn't afford treatment if payments eliminated 1,723 (71.8%)

Wouldn't seek treatment if payments restricted 771 (32.1%)

Mr. **SAXTON**. Thank you.

I just have one quick question of this panel. One of the differences that was pointed out by Mr. Pierce between the Federal system and our State system is the fact that charges that are incurred by patients in hospitals that are not covered under the DRG system cannot be passed on to anyone else, and that seems to be a fairly, maybe the major, difference as far as what I can see in how the two systems operate.

Is that what makes the New Jersey system more efficient, and, if it is more efficient, costwise, because of it, do you see it affecting medical care?

Mr. **PIERCE**. I believe that from the work that we have done, the data that we have seen, the answer is yes; that is the reason that the hospitals in New Jersey are more efficient than most of their colleagues around the country in that it is an all-payer system, and the hospital and its medical staff have to be devoted to using their scarce resources wisely.

Now, the second question was, does that have an impact on the quality of care? And our study, and the studies done by the PSRO's, the data that we have accumulated, what we have seen from the outside is there is no statistical evidence that in any way there has been any diminution of quality.

Remember, even under the DRG system, New Jersey or national, it is still the physician who is the discharging authority, not the hospital or anyone else. It is true that the PSRO says this is when you are in danger of losing payments and that has been pointed out many times is a private organization funded by the Federal Government.

Mr. **SAXTON**. May I ask Jim Schuessler for his response to the second part of that question relative to the quality of care?

Mr. **SCHUESSLER**. Yes. I think that the relationship here is one which is difficult because there is no single agency responsible for it. I think that Charlie pointed that out very clearly. That is, that the reimbursement system, which focuses on the income, the revenue to the hospitals, is one which, in New Jersey, is controlled 100 percent by State government, and whether one embraces that concept or not is irrelevant to our discussion here.

It is New Jersey State government which controls the reimbursement system. The PRO system, whereby a contract agency of the Federal Government comes in independent of the hospital, independent of the attending physician, and, in fact, independently of State government and its reimbursement system, and makes determinations on an after the fact basis as to whether or not there shall be reimbursement for a particular patient's care, is one that smacks of inequity. It creates, I think, the tension that you are hearing from your constituents, and it creates a perception that there is something amuck.

Now, I am not in the possession of statistical evidence that documents the efficacy of the PPS system one way or the other. But, I have heard the same ill-at-ease concerns that all of you have expressed earlier in the day with regard to our patients' and your constituents' concerns that there is a series of pressures at work in our society and in our health delivery system that are, in some cases, preempting the best judgment of the attending physician, and I think that it is in that area that many of us have great concerns.

Again, that is independent of the reimbursement system, whether it comes through the Federal PPS system or, in New Jersey, the all-payer system.

Mr. **Saxton**. Thank you.

Mr. Tauke?

Mr. **Tauke**. I have no questions.

Mr. **Saxton**. Mr. Smith.

Mr. **Smith**. In the interests of time, I will be brief.

Mr. Pierce, you indicated that the waiver for outpatient services has not been provided.

Could you tell the committee why that decision was arrived at, and how do you assess New Jersey's chance in court?

Mr. **Pierce**. The official reason why Medicare declared "unapprovable" our waiver was that it would cost more than Medicare system on its own. This is obvious. We said that in our application, that it would cost more because we had uncompensated care added on to it.

Our belief is that the whole system being so efficient, we documented, we will have enough savings on the inpatient side we can take care of the uncompensated care on the outpatient side.

Medicare, in one of our many meetings, their staff said, well, that is our decision. We decided to separate part A, part B. We said that that is foolish.

We have in New Jersey for 4 years, 5 years now, a hospital reimbursement system that incorporates both, and that is what we are in court arguing about.

We also believe that the statute says that HCFA or the secretary must give payment or give a waiver for hospital reimbursement system. We do not believe it is separated into part A, part B.

The Federal court will decide, or at least look at the issue, on Wednesday. Our attorneys are saying it becomes very quickly a technical question, 50/50.

Mr. **Smith**. Thank you.

Mr. **Schuessler**. I appreciate that your question was very narrow and Mr. Pierce has responded to it appropriately on a very technical basis. But, I would just like to offer a more generic response on behalf of the patients that our hospital serves in the sense that I have, in the sense that they give to me, is that the Federal Government has failed us.

Medicare has promised what our Government seems unwilling any longer to pay for, and I know that that may be an oversimplification of an exceedingly complex issue. But, I think that you should be aware, if you are not already so, that the elderly population of this country is losing confidence in its Government's ability to govern, at least as it pertains to the provision of health care benefits for the elderly, and increasingly the providers find themselves caught in the middle of a morass that is the creation of expectations on the part of the public that were reasonable expectations in terms of the rules as they were established.

But, as those expectations become increasingly difficult to fund, we are in for a lot more frustration, and I hope that your committee will take that into consideration as you develop an approach to meeting the problem.

Mr. Saxton. Thank you all very, very much for your help this afternoon, and thanks for being with us. We feel that we have gotten a great deal out of what you have told us, and, in particular, I think, the difference between the way the State of New Jersey operates and the Federal Government, and I think we have learned a great deal.

Thank you very much.

The first person from the public is Mr. Tom Colitsas, who is here on behalf of Mayor Jack Rafferty, Hamilton Township, NJ. OK.

Okay.

STATEMENT OF TOM COLITSAS, ON BEHALF OF MAYOR JACK RAFFERTY, MAYOR OF HAMILTON TOWNSHIP, NJ

Mr. Colitsas. Thank you very much, Mr. Chairman, Congressman Tauke, Congressman Smith. I have here Mayor Rafferty's prepared statement which I will read for the record.

[The prepared statement of Mr. Rafferty follows:]

Prepared Statement of Mayor John K. Rafferty, Toms River, NJ

Good morning, I am Jack Rafferty, Mayor of Hamilton Township, New Jersey, I welcome the opportunity to again testify before this Committee. Congressmen Roybal Smith, Tauke and particularly Congressman Saxton are to be commended for having this regional hearing and providing those people in the front lines, so to speak, the opportunity to convey their views to our representatives in Washington.

This is a fine example of government coming to the people to find out the facts rather than forcing the people to take their concerns to the policy makers. The health care of America's elderly is, as I testified before this Committee in Princeton a couple of years ago, an area of vital concern to me and to my constitutents. I think Hamilton is a microcosm of the concerns of this Nation's elderly. Between 1970 and 1980 in Hamilton we had an increase of almost 40 percent in the number of persons over age 65. As an elected official at the local level I believe it is vitally important that we have these periodic regional hearings where we are given the opportunity to convey what we have heard from our constitutents to our elected representatives in Washington.

As you may know, Hamilton is one of the largest municipalities in the State of New Jersey and one of the fastest growing. During the last decade our rate of growth was more than double that of most of the State. There appears to be two problems related to the access to health care for our elderly that you must address. In many instances there is an absolute shortage of practitioners or facilities to serve the needs of the elderly in a given area, while at other times, population shifts cause a maldistribution of the needed health care resources. As elderly populations dramatically increase in an area, the health care resources may lag behind the population growth. Hamilton is a typical example.

While most of your attentions have rightfully been directed at the financing of the health care services, you should also consider creating incentives so that the health resources are located for the access of our senior citizens. Whereas Trenton, our sister community, has experienced a significant decline in its rate of growth of their population, we are experiencing an increase and, with this increase and particularly with the growth or our elderly population, comes all the concomitant problems associated with the elderly and their health care which is of paramount concern to America's senior citizens. I hear these concerns every day and I cannot thank you enough for having this regional hearing where I can transmit these concerns and my recommendations to you elected representatives. I have watched carefully the trends in health care in America and have sought advice and counsel from those more knowledgeable on this subject than myself. This I felt I owed the senior citizens of my constituency just as you owe it to all America's senior citizens.

Let me now turn my remarks to the purpose which is Prospective Payment. As I noted some two years ago in my testimony before this Committee I laude the Prospective Payment endeavor which has compiled a commendable record of achievement. I would wholeheartedly endorse the sentiments expressed in the June 11th

Congressional Record by Congressman Tauke where he entered for the record the lead editorial from the New York Times of the same day. Yes, Prospective Payment has been a victory of social policy but, and there is the big word, it must not be taken or viewed as the be-all and the end-all. Whereas everyone is to be commended from Secretary Heckler to Carolyne Davis, as noted in the remarks of Congressman Tauke, it should also be pointed out that there are new horizons and new problems that surface as a consequence of Prospective Payment. For all the praise that can justifiably be heaped on the altar of Prospective Payment, the concerns of social policy that I alluded to in my Princeton testimony are still with us. To some extent they have been exacerbated by the enactment of Prospective Payment. Let me elaborate on this last point.

Prospective Payment has indeed done much to make hospitals more cost conscious, and more efficient. It has reduced the length of stay significantly over what had previously been the case and has turned around the curve of continual Medicare cost increases at rates that are two and three times the consumer price index. This is commendable. But how does this translate into out-of-pocket health care costs for America's elderly? From what I am hearing it increases their costs and the concerns I raised at Princeton have yet to be addressed. We do not have catastrophic coverage yet. America's elderly are still at risk for untoward health care costs should they be subject to a stroke or some other type of long term illness. Do we ask their families to bear the brunt of these costs? I think not, I think the issue now to be faced in Washington is how do we take a good thing and make it better. I speak here about catastophic coverage for health care expenses.

I have read the recent recommendations of the Social Security Advisory Council which, as you know, focused on Medicare. In that report I noted that catastrophic inpatient, acute, and outpatient care was immediately affordable to Americans for the modest sum of approximately $50.00 a year. To the members of this Committee I would say that as a Mayor I know not what it takes to make this happen but I would urge you to make it happen. The costs are small and the needs are great. The only missing ingredient is Congressional action to make it happen. Don't leave America's elderly at risk for astronomical expenses. If you take any message back to Washington from my testimony take that back. I would even venture to guess, that the mental peace that would accompany the known fact that they were covered for catastrophic illness would actually reduce Medicare's health care expenses!

The baton has been passed to this Committee and I hope my input has helped you in your task to do something about the follow-on to Prospective Payment. I am tremendously concerned when I hear Senator Heinz state in public that "Medicare patients, as a consequence of Prospective Payment, are being discharged quicker and sicker and some may even be discharged prematurely." Senator Heinz who, as you know is Chairman of the Senate Special Committee on Aging, has stated that older patients are "being sent out into no-care zones without access to health care they so urgently need". Senator Heinz's remarks are prompted by a recent General Accounting Office report. I obviously did not come to tell you what, I am sure, you already know. But let me tell how that translates in my area. In Hamilton we have three nursing homes: Donnelly which is run by the County and is the only nursing home that accepts Medicaid patients, it has a capacity of approximately 240 beds.

We also have a nursing home in Mercerville and we have St. James Nursing Home. The total capacity of these three facilities is approximately 450 beds, Mercerville with 100 and St. James, 120 beds. In each facility we have waiting lists and, as I mentioned earlier, I have an elderly population which has increased almost 40 percent over the last ten years. My question is, where do those needing long term care go? This question is one for which I do not have the answer but which needs, as Senator Heinz has amply noted, serious consideration. "No-care zones" are inconsistent with a global health care strategy. I have no evidence that indicates that hospitals are tending to discharge patients early because their DRG payments have run out; however, I do know from my own locality that a full spectrum of care is desperately needed.

We are living now through a period of five generations of Americans. This phenomona should not be taken lightly as, and I cannot speak for Biblical times, this is a first in the history of the world. I recently visited a nursing home in my locality where a woman said, "Mayor, I have to run, I have to get home and take care of my granddaughter," This woman was visiting her grandmother. Five generations of Americans who are being supported by one, at best, two people's payroll tax. This tax funds the Medicare program and the Social Security program. Again I don't want to appear pedantic but I'm told when the Social Security program started there were 17 people paying in for each person collecting. Now we have less than four people paying in for each person collecting and I've read that, by the year 2000, we will have two people paying in for every person collecting. Take this statistic, two people paying in for every person collecting and couple it with the fact that we are going to have, in the United States in the very near future, better than one hundred thousand people who are over 100 years old. Members of Congress, the demographics are swamping the Medicare program. I wish I had the answer but I do not but I do hope I convey that your task as members of the Select Committee on Aging is nothing short of monumental. We have always been a caring democracy and we are going to have to care for more and more elderly Americans. Where are these funds going to come from. I am confronted at the local level with budgetary problems and I know we now confront a $200 billion deficit at the National level. I don't think that the United States must become a socialistic country, but I also think the innovative thinking is needed on how we are going to take care of America's elderly. I ask you to put your minds to the task of coming up with the answers and that is primarily why I have presented this testimony today.

It may well be, as several have indicated in the literature, that capitation approaches to health care are the answer. I've noted that in the last year the rate of growth of prepaid health care programs in the United States has more than doubled the rate of the prior year which had also set a record rate of growth. It would not surprise me that in the forseeable future a significant portion of our elderly are enrolled in health maintenance organizations or competitive medical plans. My concern that I wish to bring to this Committee however is, will these plans be established in areas that will adequately serve the elderly? Is there ever going to be a sufficient demand for the development of a prepaid capitation program, in, Seaside Heights, New Jersey or Dubuque, Iowa or Minot, North Dakota? A pluralistic approach is probably what is called for. While capitation may fix many of our problems with respect to the full spectrum of care, we need to think about how to fix catastrophic coverage and also long term care coverage for America's elderly that capitation is not going to address. Capitation is a partial solution to the health care problems we face. It is not, as I said about Prospective Payment, the be-all and end-all.

Members of this Committee, as I said at the outset, I do not have all the answers. But someone once remarked to me that a good question beats a good answer. The knowledge and the resources that Washington can bring to bear on this vital issue are far greater than what I, as Mayor of Hamilton Township, can bring to bear. I do hope, however, that I have surfaced some concerns that you will studiously look into in Washington. I look to this Committee to come up with an innovative and creative approach for meeting the health care needs, including catastrophic coverage, to all the elderly of America. Just as you have set new horizons with Prospective Payment, new horizons can now be set on these other concerns which are foremost in the eyes of our elderly citizens.

In closing my testimony let me, again, reaffirm what I said before this Committee in 1983 and I quote "I am particularly concerned that needs of our older American's be given the thorough and proper consideration in the councils in Washington that they rightfully deserve. These people in the twilight of their years, the Americans who were responsible for the growth and development of this great Nation are increasingly finding that health care is depriving them of everything they have worked a lifetime achieving; that is a happy and comfortable retirement." Members of this Committee I still believe this and I still think your task, while you have moved out in the right direction, is yet to be fulfilled. Give America's elderly the peace of mind that they deserve.

Let the next editorial that appears in the *Congressional Record* be the banner announcing the enactment of catastrophic coverage for America's elderly, I urge you, don't let your task be half finished.

I trust my comments have been helpful and I again wish to thank all the members of this Committee for this opportunity to express them. I look forward to future regional hearings of this nature and you may be sure I shall keep my ear to the ground and relay to you and your colleagues the concerns that I hear so often from the elderly Americans residing in my jurisdiction.

Mr. SAXTON. Thank you. Real good to see you again.

Ms. Squitieri.

Ms. SQUITIERI. Perhaps I should go to this side. I do not like to turn my back to people.

STATEMENT OF MS. SQUITIERI, SENIOR CITIZEN

Ms. **Squitieri**. Thank you. Thank you very much. You have to excuse my voice. I have a bad cold, but it is much better now. I had a very bad cold.

I want to thank you for having this hearing, I guess I should call it a hearing, for listening to us. I thought there were supposed to be more of you.

Mr. **Saxton**. There were, but Congressman Hertel from Michigan could not make it.

Ms. **Squitieri**. I also want to thank Congressman Saxton. I very much appreciate your letters in response to mine, and you certainly keep me up to date.

I am also very appreciative of your helping out and sticking with us because I come from a community, a particular community, of senior citizens. So, what you do for us is greatly appreciated.

Is this seminar something just for Medicare or are there other things to be taken up?

Mr. **Saxton**. We have an agenda which was health care for the elderly. The first part of the program was health care for aging veterans, and that is the subject of the hearing.

If you have something that you think is important, if you want to take a minute and discuss it, OK.

Ms. **Squitieri**. Well, I would say this, that as an elderly person, we are all very deeply concerned with, right now, the proposed, of course, as you know, the budget. The Senate voted against it, and the House has voted for defense. The House voted against the budget—I mean, the House voted against the defense and for the COLA's.

Now, it seems kind of ridiculous that one could pick defense against the needs of the elderly, do you not think? I mean, one can at least be—it is incredible.

Mr. **Saxton**. Well, what happens with the budget process in Washington, DC, is the Senate does its thing——

Ms. **Squitieri**. I know, I know.

Mr. **Saxton** [continuing]. And the House does its thing. All I can tell you is that there were four budget proposals that we voted on in the House.

The one that passed had COLA's in it. The three that did not pass also had COLA's in it. So that every proposal that came out of the House had provisions for COLA's in it.

In addition to that, the House, I think, has committed itself to full COLA's even in a more strong way because following the adoption of the budget that passed, there was an attempt by a Member of Congress to freeze COLA's for 1 year, and he had lost overwhelmingly.

Ms. **Squitieri**. I see.

Mr. **Saxton**. So, all I can tell you we do not have a lot of control over what is going on in that Senate/House conference committee. All I can tell you is that the House has one commitment, that is very strong, that almost everybody agrees on, and that is the retention of COLA.

Ms. **Squitieri**. I wish you a lot of luck with it.

The other thing that we are concerned with is, of course, what everybody is concerned with here. We seem to be getting less and paying more and more, and besides being threatened by the COLA's, we are being threatened by cuts in Medicare, and we have been getting them gradually more and more.

I wish we could have someone from your staff just live here for awhile with us, and see what is happening around here. My time goes between my friend, who is bedridden and cannot get out, to another one in a nursing home, who has Alzheimer's disease, and it seems kind of funny that the elderly should be taking care of the elderly, but that is what is happening.

Some of them do not want to go to their children's homes, because, well, as one woman explained, this may sound kind of funny, she said I went to my son's for Easter and came back with the most awful cold. My daughter-in-law had the windows open all the time. Well, of course, that is one way of getting rid of your mother-in-law. I know. I know that.

Younger people have their houses at one temperature and the elderly have their houses at another temperature, and never the twain shall meet.

Well, besides the higher premiums for Medicare, we get higher Blue Cross and Blue Shield premiums, and that is out of sight. It is absolutely ridiculous. We get very little.

I switched to AARP recently and I am hoping that that is going to be better.

May I suggest that we have a committee established to suggest health systems in other countries? I know that in Canada people are very satisfied up there with theirs, and in other countries—back in 1983 or 1980, we ranked fifth in the benefits to the elderly. That is kind of pretty awful for a country as great as ours, which I think is No. 1 in the world.

Why should a family be penalized just for putting Alzheimer's patients in a nursing home? I am sure that people should be able to pay for their homes, but it seems to me that $2,000 a month for a nursing home is very stupid, and $2,000 a month is what we pay around here, and if you do not have it, God help you. You are on Medicaid where you are down at the bottom of the barrel, and we can wait for months for a bed.

So, I would hope that you could have some—things like a cigarette tax. I know that Mr. Helms would scream, but a cigarette tax might help pay. After all, it is their patients, their people, who are putting—who are mounting the costs for nursing, the lung patients, the cancer patients.

It makes sense. I had another suggestion here. I think that young people should be better informed as to the benefits of Social Security to them. They think it is way off when they are going to be old. They do not realize that their children are—if there is a family and somebody in that family dies, their children will benefit. It never comes to their minds, they do not think of it that way.

In some cases, there is mounting antagonism against the elderly. There is meanness in the land, and I think not only does it show up that way, but, for example, the meanness in putting taxes on our property here really amounts to an additional property tax for us, and they will not allow us a reduction for our homes. That is another perpetration on the elderly. How many blows can the elderly stand.

Thank you.

Mr. **Saxton**. Thank you very much for your testimony. We really greatly appreciate your taking the time to come here, and I am not sure whether we have somebody who wants to come and visit or not, but I will ask.

Mr. **Tauke**. Mr. Chairman, I have to depart, but I just want to say to you that after that great testimony, I hope that all Members of Congress will support my bill for a 32 cents tax on cigarettes up from the current 16 cents, and 24 of 32 cents goes into Medicare trust fund to pay for some of the programs that we have been talking about here this morning.

And, so, I like your idea. Thank you. I would also congratulate Jim and thank him for inviting us. Sorry I have to leave before some of you have testified. I will read what you say when the reporter gets it put together for us.

Thanks very much.

Mr. **Saxton**. I believe it is Mr. Giubardo. Is that right?

STATEMENT OF MR GIUBARDO, VETERAN

Mr. **Giubardo**. That is right. How much of the cigarette money is going to the veterans for rehabilitation? Keep that in mind, too. I would like to—is the other Congressman leaving, too?

Mr. **Saxton**. They have a plane to catch.

Mr. **Giubardo**. Do not forget the veterans when you vote.

Mr. **Saxton**. They do have an airplane to catch.

Mr. **Giubardo**. Congressman, I just have a few words I would like to bring up about the veterans, increase in the aging veterans.

I think the Government has let us down, No. 1. Keep that in mind. The other thing is that from listening to all these witnesses we had about the aging veterans, all I got out of that is that there are two things that are roadblocks for the aging veteran. The first one is the Government will not spend any money for the aging veteran. The second one is they are not dying fast enough.

That would settle it for them right away, if they died fast enough, they would not have to worry about financing all these different plans they got for the aging veterans.

I myself am a veteran. I am also military retired, and getting back on the subject of veterans affairs, now they are starting to affect the military retirement, which was given all kinds of promises when we got out of the service.

I—most of my medical problems are taken care at Lake Heart Clinic. Now, the last 6 months or so, not only they have not got doctors, they are cutting down on the pharmaceutical—the pharmacy part of it. You speak to the guy, he only allows so much budget, and when that budget runs out, they have to wait for a new appropriation to get more medicine.

You say well, what do I do now? Well, we will get your prescription. You go to Fort Monmouth, you go to Fort Dix, go to Fort Hamilton, and you do not know if they got it, but you have to call them first. Go to your own pharmacy.

Now, I believe in cutting budgets, but they certainly should not cut budgets where the promises were made to these people. They found the money, but they got you clothes, they got you a weapon, they got you a house to live in, they fed you three times a day, they took care of you when you were sick, they made promises, do not worry, you are taking care of the country, when you get out, we will take care of you. Well, they are not doing it.

Now, all I want you to do is keep that in mind when you do your voting, not to forget the aging veteran. I had another one, but I do not want to make it too long. That is all I have to say. Thank you.

Mr. SAXTON. Thank you, sir, and I want you to know that at least there are three people in the U.S. Congress who are here today who understand exactly what you said and that is why that was the No. 1 segment of our program because we know it is a problem. We know that veterans are entitled to certain benefits. We know that they are provided at a level which is less than desirable.

We also know that we have to find ways to fund various parts of Government, including the funding of proper veterans benefits. That is what we are trying to do. Mr. Smith is a member of the veterans affairs committee, and I know that he is directly involved in it, and I have been involved in it as well.

So, I appreciate very much what you said and thank you very much.

Mary Lou Hyman.

STATEMENT OF MARY LOUISE HYMEN, ASSOCIATE ADMINISTRATOR, GARDEN STATE REHABILITATION HOSPITAL

Ms. HYMEN. My name is Mary Louise Hyman, and I am the associate administrator at Garden State Rehabilitation Hospital.

I am here to speak on two issues. One is the proposed VA clinic. Back in the early 1970's, when there was a severe gas crisis here in the area, we contacted—Garden State Hospital contacted the Veterans' Administration and asked them if they would allow us to provide services to the VA population in this area. We have an amputee clinic that provides much outpatient rehabilitation services. They, in their good wisdom, said that they thought that was a dynamite idea, and they allowed us a contract to provide outpatient rehab services.

Of course, when the gas crisis finally blew over, if that is what you can call it, those services were then no longer allowed, and went back to having the people of Ocean County having to drive 2 and 3 hours to receive their care.

There is precedent for having contracted services. There is precedent for allowing a community to be able to provide services to its own people rather than having them go many, many miles in order to get those services, and I think that perhaps if the VA committee would search back in some of its records, and would also search into some of its present records, because I know of an institution just recently that received VA—a VA contract to perform the full range of VA services, and this is a small clinic in upstate Pennsylvania for the people in that area.

So, there is precedent for providing the kinds of services that the clinic coalition here in Brick has been talking about, both on a separate clinic bill basis and also on a coalition basis, where services that are already available and underutilized can be used to serve the population that now has to drive 2 hours away to get checked.

So, we do fully support the clinic concept of the VA clinic in this area.

The other thing, if I take off my name tag as associate hospital administrator, is I am also a member of the American Occupational Therapy Association, and I would like just briefly to comment on home health care service.

There is presently an amendment before the Senate and Senator Boggs has initiated that amendment. It has broad support on a bipartisan level to add occupational therapy services to the home health care model.

This bill or amendment to the Medicare Act has been to several times and it, again, is coming up for review. The provision of occupational therapy services presently are such that if a client or if a patient needs occupational therapy services, they must also receive nursing services and physical therapy services.

Well, in many cases, patients do not need physical therapy services or do not need nursing services, and do need occupational therapy services. This morning, Sister Confroy made a comment about a lady who had upper extremity injuries due to a fall.

This particular lady could have very much benefited by occupational therapy services because most—much of what she probably needed was retraining in independent living skills. How do you do things that you could—that you cannot do because of a disability? How can you be retrained to do them with your disability? That is the primary function of occupational therapy, and I think that if occupational therapy services were provided on a more regular basis, without all of the constraints that are put on the provision of those services, prior to it being authorized, that—and we do have studies through the American Occupational Therapy Association, that will document this, that we can reduce the length—not only reduce the length of hospital stays, but we can also reduce the amount of home health and homemaker services by providing proper therapy services and adaptive equipment to people that go home and that need some aid.

Mr. **Saxton**. Who would make the determination as to whether or not this type of therapy is to be prescribed? The doctor?

Ms. **Hyman**. It would be ordered by a physician, and it would also become a part of the care plan that is developed by the home health agency. Occupational therapists are on staff with most home health agencies.

As a matter of fact, they are required by Medicare to have occupational therapists on staff. Yet, they put so many roadblocks prior to the utilization of those services that they are very much underutilized, and I should think, in many cases, the cost-effective nature of home health care is not greatly served by those roadblocks.

The American Occupational Therapy Association has a lot of information that we will be providing to you and to your committee about the addition and the expansion of occupational services for home health.

Thank you.

Mr. SAXTON. Thank you very much. Mr. Greenberg.

STATEMENT OF WILLIAM GREENBERG, VETERAN

Mr. GREENBERG. My name is William Greenberg. I am a resident of New Jersey for 14 years. I am also a veteran, World War II, and was discharged in 1945, and fortunately, I never needed any services. I feel very happy about that, but some of my friends are not so lucky, and, of course, it would take too much time to go into that.

But, I have no love for the VA, for what they have done to some—for some of the refusals of some of my friends. Now, I happen to be fortunate, perhaps, in one way. I happen to have been connected practically all my life with the theatrical industry, as a sound engineer, and also motion picture projectionist.

That made me eligible, through my connections, to become a lifetime member of the Will Rogers Hospital, and that was the finest in the country, and I feel very good about all that because I will never have to come to the VA, and that is it. That is all I am going to say on the VA.

Now, I will get back to Medicare. As I said, I am a resident of 14 years. When I was here about 10 years, my wife suddenly took ill. She was taken to the hospital. Within a few days, we had several doctors on the case, one of the doctors called me in and told me that she had a serious illness.

Right away, I received a letter from Medicare, somewhere about 4 o'clock, I received my notice before 4 o'clock, telling me that my wife would have to be taken out of the hospital as of that date. Now, I understand checkout time is somewhere about 11 a.m. or thereabouts.

I spoke to one of the doctors, told him about the letter, he said there was nothing that could be done. He says I will not get involved in Medicare. I said but what if something happens. Said I have no choice.

I said, but, in your opinion, can she leave the hospital? He said absolutely not. I said then what do we do? He said the only thing is perhaps if we order more tests. I said but, doctor, what are the tests going to prove? He said nothing. Maybe we will learn something. I said well, for the doctor to learn something, I am not going to let my wife sit in the hospital for more tests.

So, I said, well, I have no choice, but to take her home, and to have the doctor arrange for Medicaid, and I brought her home Saturday. Friday, it was too late for us to make arrangements.

When she left the hospital, the doctors told us there was no way we could handle it at home, and I knew it, but they said I had no choice. She stayed overnight. The very next morning, we had to go down. I had to take my wife home.

She went back to the hospital. The hospital charged me for the time she was there. I paid the hospital. The doctors billed me for readmission, for readmission, and I said, this is absurd, she only stayed home one night.

So, I paid the doctor, I paid the hospital, I did not want to make the issue because I had a problem on my hands as is. Money had no value to me, but this is why I had been to Medicare. I was ripped off, I was sold out, and I think when all this money goes across the ocean to foreign countries to help starving people, I believe the Government does not give a rap.

I have been paying into this, and until twelve years ago when I came here to retire, I never had anything out of Social Security until two years ago, and they paid out a pittance compared to what I paid in. But, I think that Medicare—I do not know. I do not think the Government gives a rap about the people, to be honest with you, with all due respect to you, but that is how I feel about it.

Thank you very much.

Mr. SAXTON. Mr. Greenberg, I would just like to say that stories and episodes such as the one that you just described certainly bring home to us, who view these programs sometimes, as just that, programs, bring home to us the fact that they have a very dehumanizing effect on people and people have to deal with them on a firsthand basis, and when they do not work right, as they did not in your case, it points out why the system needs to be fixed or modified, as one of the people said.

The other thing I would like to say is that your—the story that you just told of your wife is also a symptom of this lock-step system that they, in 1981, put in place, and then modified in 1983, to provide for this prospective payment system.

Just as everyone is different, everyone's illness is different, and what this system attempts to do is to treat everybody the same by saying that if you break your arm, you are allowed a number of days in the hospital, whatever the number is or a number of dollars to fix the broken arm, and each illness is treated in that way.

I have heard stories similar to yours, where the time ran out, people had to go home. I have heard stories where the time ran out and the hospital kept the people anyway and, of course, this is under the State system, where the hospital cannot be reimbursed.

So, the reason that we are interested in being here today to hear this testimony is because we would like to try to modify the system in some way, so that these things do not occur, and, at the same time, provide for some cost savings because, as you have probably read in the newspapers, the system is said to be in not good shape, that it could have severe financial problems and go broke some time in the early to midnineties, and we have to keep that in mind as well.

But, we are appreciative of you coming here today to tell us of your personal experience with the Medicare program.

Are there any other witnesses today or anyone else who would like to say anything? [No response.]

If not, I will declare the hearing officially closed.

[Whereupon, at 1:48 p.m., the hearing adjourned.]

APPENDIX

BUCKELEW & ASSOCIATES,
June 13, 1985.

Congressman H. JAMES SAXTON,
Congress of the United States,
Washington, DC.

DEAR CONGRESSMAN SAXTON: I have been most interested in following your action in attempting to preserve Social Security and Medicare Benefits. As a member of the National Committee and as a lifetime Employee Benefit consultant (50 years), I am vitally concerned with the proposed elimination of COLA and the Medicare reductions.

We senior citizens have financed Social Security and Medicare and I fail to understand how and why the government contemplated using any of these funds to finance the federal deficit.

It was with great interest that I learned you were going to hold a hearing on the subject of health care for the aging population on June 24, 1985 at Holiday City. I look forward to attending and meeting you at that time. Please be prepared to comment on why there is not a more concentrated attempt to limit the amount of awards in malpractice suits. I feel that lawyers and courts are milking the public by permitting the astronomical awards. If a maximum was established, it would effect a sizeable reduction in premiums for malpractice insurance with resultant reductions in health costs.

I look forward to the June 24th meeting.

Sincerely,

ERNEST B. ARMSTRONG.

PREPARED STATEMENT OF CRAIG A. BECKER, VICE PRESIDENT, NEW JERSEY HOSPITAL ASSOCIATION, PRINCETON, NJ

Members of the Committee, I am Craig A. Becker, Vice President of the New Jersey Hospital Association.

The New Jersey Hospital Association, which represents all the hospitals in New Jersey, is testifying today at this field hearing of the House Select Subcommittee on Retirement Income and Employment to lend our assistance to this Subcommittee through our experiences with New Jersey's Prospective Payment/DRG experiment. Congressmen Saxton and Smith, we know you have long been interested in hospital and health matters, and we appreciate the opportunity to address the Subcommittee on this most important matter affecting the delivery of health care to the people of New Jersey.

I would like to address my remarks to the issue of Health Care under the Prospective Pricing System and the DRG system as it relates to New Jersey and to comment on its effectiveness as a mechanism to pay New Jersey hospitals.

We applaud the concerns of this Subcommittee and of Congressmen Saxton and Smith over the health of our health care system and we would caution the members of the subcommittee not to be hasty in drawing conclusions from hearsay, misinterpreted or incomplete data. There is too great a temptation to sensationalize and to speculate on the effects of the PPS/DRG system. However, one thing we have learned from our experience is that New Jersey has held the line in the cost of health care and has been able to do so without jeopardizing the quality of care. It is true that the DRG system has shortened length of stay in our hospitals, which means patients are going home more rapidly than in the past. It is because of this that we recognize the need for an examination of home health care at both the state and the federal level.

If there is anything we have learned, however, from our experiences, it is that the financial integrity of each individual institution must be preserved. If the federal government designs a system which averages all hospitals' costs per diagnosis to a single rate, the catastrophic result could be average care, average services, and average quality.

New Jersey experiences must always be viewed in light of the State's hospital rate setting law, P.L. 1978, Chapter 83, which was enacted by the New Jersey Legislature. Among other things, this law spreads the costs of uncompensated care (indigent care costs and bad debts) among all payors. It also guarantees the solvency of effectively and efficiently operated operated hospitals. As you know, the Medicare PPS reimbursement system does not include these features.

Official statistics show that costs per any unit of output selected, including both admissions and days, have risen at a slower rate in New Jersey than in the nation as a whole since the DRG system was implemented here in 1980. However, costs also rose more slowly in New Jersey *before* DRG's were implemented since we have been a leader in cost containment efforts. New Jersey has had some form of rate setting since 1969. Prior to that, we succeeded in containing costs through a voluntary formalized budget review process.

One evidence of our ongoing effectiveness is that for 1978 to 1983, New Jersey ranks 51st, absolute last, in the United States in percent of increase of both total expenses and total net revenue per adjusted admission.

However, there are clouds on the harizon. The New Jersey Hospital Association is very much concerned about the current freeze on both PPS rates and on the movement toward total payments on the federal rate. We have run models which show New Jersey losing between $60 and $70 million if both freezes are enacted. In effect, New Jersey in being doubly penalized—one, it loses its inflation increase, and two, it is significantly below the national rates paid under PPS and therefore will lose if the move to the national Payment System is halted.

We would urge the Subcommittee to use its influence to see that at the very least, the move to national rates goes forward.

Finally, let me thank you for your time, interest and commitment to meeting the health and hospital needs of our seven million residents of New Jersey.

Prepared Statement of Robert K. Blom, Physical Therapist, President, Monmouth Rehabilitation, Inc.

HAVE PATIENT'S POST HOSPITAL NEEDS CHANGED?

There is no doubt that post hospital needs of the patient have changed. Patients are being discharged sooner than before which has placed a greater emphasis on the Home Care Service agencies. Patients require more intensive nursing and rehabilitation post hospital discharge to re-establish their lives in the home environment. This includes an even greater empahsis on placement of Home Health Aides. I have seen an increase in the awareness in this area with changes in regulations in the Medicaid and Medicare to support this need. I have experienced less support and recognition from private insurance industry and I see the need to expand Home Health Services coverage within all insurances. Patients now are returned to the home environment while they are still in the recovery stage of their illness or recent disability. Patients and their families, at this time, have not adjusted physically or psychologically. They require more help and support at this time. We have experienced situations where the maximum support available and possible under current regulations was not sufficient to prevent regression of the patient's status and re-admission to the hospital became necessary. Many of these patients, discharged at a later date were re-established to their home environment and sucessfully "after the second discharge because their needs were better assessed and sufficient recovery time had elapsed." However, re-admission may not have been necessary if expanded "man" hours had been allocated toward their care during the initial discharge adjustment period. Many times the cause was not their physical status as much as it was due to their psychological status—fear, frustration and feelings of hopelessness.

HOW ARE PATIENT NEEDS BEING MET?

I feel that the agencies in our geographic area have responded extremely well to patient needs considering the increase in patient numbers and specific needs. There have been, due to the increased needs, times when we have experienced "manpower shortages", however, the present agencies and personnel have responded to meet the demands and will continue to do so as long as health care personnel can be made available. The system is well established as long as it is supported. I am concerned, however, about the cooperation between hospitals and the present county

Health Care Agencies. The established agencies have the appropriate mechanisms to promote coordinated care and patient entry into their system. However, there has been an increased incidence of dual services involvement which have been ordered creating confusion and delayed care. This has occurred in some incidences for reasons of "competition" which has recently become more prevalent within the health care community. This has occurred not because various hospitals and agencies are "competing" to establish the best service, they are "competing" for the "patient dollar".

HOW HAVE LONG TERM COSTS BEEN AFFECTED?

In believe long term costs have basically been reduced with the present system when considering the cost per patient. I also feel that home care status is a better alternative to institutional care. We do have a temporary problem with transition to the present system, however, as long as the present agencies are supported, not forced to compete, they will help to establish a humane and cost effective system. The expansion of Home Health Care and Out-patient Services will eventually continue to reduce cost per patient by preventing institutionalization. I believe that the supporting and developing of Home Care Services to enable early discharges from institutions and developing, promoting and preventing developmental disability of the aging and the presently disabled, we can reduce the need for institutional care and further reduce total cost, not just cost per patient.

ARE PATIENTS HAVING ACCESS PROBLEMS?

I have mentioned in my eariler commentary that I have experienced some problems due to developing competition among health care providers, however, I hope that this will be resolved in another arena. I have not experienced patients having access difficulties due to the present system as it exists. They have had access problems due to comprehensive planning difficulties due to competitive negligence, sudden and/or premature discharge from hospitals and/or lack of appropriate referral and information to the agencies. I have experienced some access difficulties due to manpower shortage which has resulted in delays in service, however, this has been less problematic in the past year now that agencies have started to catch up to the needs of the patient under PPS/DRGS regulations with eariler discharges.

We do have continued access problems for patients that have not been institutionalized and/or have been previously disabled. Present regulations do not effectively cover these situations. Many patients are denied coverage unless they have been institutionalized and have been classified as "maintenance".

These people often cannot afford private pay service and therefore are denied or forced to deny themselves appropriate service. These patients then will become more infirm, disabled and dependent. Prior to PPS/DRGS and the strongly enforced PRO, patients that presented deteriorating health status were more readily readmitted and eventually discharged so they could be managed within the guidelines of post hospital care regulations. Admissions now are being denied or delayed until their status has dramatically declined. Once this situation has occurred we will see readmissions eventually at higher institutional costs, requiring more extensive and expensive treatment and care, both during institutionalization and post institutional care. There also is the probability these patients will not be able to be re-established in the home setting.

I feel that new regulations must be formulated to cover these patients so that we do have the means to maintain patients and the aging in the home in specific situations. Presently, New Jersey's Medicaid System is studying this situation on a trial basis. I feel that the need is great enough that a "trial" situation is not necessary and that Medicaid, Medicare and private insurance should move to enact regulations to meet this present need as soon as possible. Without new regulations to cover this status, patients will continue to be deprived appropriate long term care and be forced to deteriorate in an inhumane existence until less cost effective acute care is required.

SUMMARY

I have been directly involved in patient care and management of Patient Care Service for 16 years. The health care system has changed dramatically during this period with specific reference to the last 10 years. We have not only had major changes in areas of technology which have advanced the types of services available to the patient population, we have also seen major changes in the administration of these services.

Professional gains have enchanced the potential for more effective care services and have made it possible for the aging and disabled to re-establish their lives and be productive members of society in larger numbers than ever before. We must also credit a significant change in public awareness of their needs and the willingness to help the disable realized their goals. This could not have been accomplished without the dedication of professionals throughout the health care system, volunteer organizations and political forces such as yourselves, that recognize the needs of the aging and disable populations within our society.

We have not yet, however, obtained our maximum potential nor have we fully succeeded in establishing appropriate guidelines and goals to meet all the present needs and future needs of the disabled.

The present PPS/DRG system has evolved as a well meaning system, attempting to contain rising costs as well as not to deny patients necessary and justifiable appropriate care. Many times patients will be forced to leave hospitals sooner than is appropriate to meet their physiological and psychological needs. This has resulted in greater reliance and responsibility of the Home Care Professionals. Home Care is a viable alternative and, in many cases, has responded extremely well in meeting the needs of the patients. In other situations patient's needs would have been more appropriately resolved in the institutional setting.

I have also come to realize in recent years, that the same reason that institutional care has become financially restrictive will potentially occur in the home health care service area. The necessity of cost containment will cut back services and gains made in the home care system will decline as gains realized at the institutional level have already declined during the past 10 years.

How we resolve these problems is not a simple question, yet I feel I can very easily recognize the cause and reason we are faced with these problems. I am sure that we can all agree that if we recognize the cause, we can also realize a possible cure. It will require a strong will to survive and a strong resolve to see it through. We must take the "profit" out of medical care services and we must reduce the cost of administration for the services.

We have seen "medicine" become an "industry for profit". The fact that we, as medical care consumers, have had to pay a greater percent of our cost for service for administration and profit has directly and indirectly cost us not only in dollars but has cost us dollars for the amount of service. We cannot aford an "industry for profit" in the medical areas that are related to direct service care for our patients. The "patient" has become synonymous with the word "consumer". This is wrong and I contend it has no place in the "Humanities of Medicine". The disable patient does not have the time nor capability to "shop" for services like we do for durable goods. If the "consumer" does not find the right shoes at the right price today, they can wait and will survive. The patient does not have that capability and has to accept today the wrong price and many times the wrong service.

We must realize that every time a service is provided through a Health Care Agency or hospital, owned or operated by a "profit" oriented organization, "monies" are being directed away from direct patient care. The growth of the health care "industry" into "corporations for profit" should be examined and will have to be regulated more effectively if our health care system is to grow to meet patient needs and remain financially solvent.

Garden State Rehabilitation Hospital,
Toms River, NJ, July 2, 1985.

Mr. Jerry Vanderwood,
Legislative Assistant to Representative Saxton,
Washington DC.

Dear Mr. Vanderwood: We wish to thank you and Rep. Saxton for allowing us the opportunity to attend the field hearing for the Select Committee on Aging, held in Toms River on June 24, 1985.

I am enclosing additional information to be included as testimony in the section regarding Home Health Care as an Alternative. This testimony is in support of H.R. 2116 introducted by Mrs. Lindy Boggs to extend Part B reimbursement to skilled nursing facilities, rehabilitation agencies, outpatient clinics and home health services. By passage of the bill, a significant cost savings in terms of total health care dollars expended can be achieved and services could be provided in a more appropriate setting for many of the medicare recipients.

Thank-you for including this testimony in the record.

Please also see that I receive a copy of the testimony from the field hearing. Please send to the address below.

Sincerely,

MARY LOUISE HYMEN.

PREPARED STATEMENT OF THE AMERICAN OCCUPATIONAL THERAPY ASSOCIATION, INC., ROCKVILLE, MD

Mr. Chairman and members of the subcommittee, I appreciate the opportunity to speak with you today and offer recommendations for financial reform of the Medicare program. I represent over 37,000 occupational therapists, occupational therapy assistants, and students of occupational therapy who serve some 5 million Medicare beneficiaries every year. As you may know, occupational therapy is part of the multi-disciplinary rehabilitation team. Our treatment of elderly and disabled people who have suffered a stroke or heart attack, have cancer, multiple sclerosis, or arthritis, directly reduces symptoms such as pain and deformity. It also greatly reduces dependence in daily life activities, so that patients who receive occupational therapy are far more likely to remain in their homes and avoid institutionalization.

I am here today to call the subcommittee's attention to H.R. 2116, a bill introduced by Mrs. Lindy boggs last year that would complete the Medicare coverage of occupational therapy services by extending Part B reimbursement to skilled nursing facilities, rehabilitation agencies, and outpatient clinics. the bill has over 70 cosponsors in the House, and a companion Senate bill, S. 1615, introduced by Senator Matsunaga, has 8 cosponsors. The bill does not represent a major expansion of Medicare coverage of occupational therapy services, but rather a fine tuning of the system to extend coverage to less costly community outpatient settings.

Mr. Chairman, with respect to the financial crisis facing the Medicare program, it is our contention that *one* of the causes is the program's emphasis on coverage, almost without limit, of costly institutional care with inadequate attention and even disincentives to the use of less costly care in community settings. Our members are aware of the actions that this subcommittee has taken in recent years to expand Medicare coverage of home health, Comprehensive Outpatient Rehabilitation Facilities (CORFs), and hospice care and believe these were very positive actions. However, we would urge the subcommittee to continue in the direction of expanding coverage for outpatient and ambulatory care by seriously considering proposals like H.R. 2116.

With the enactment of the Medicare Prospective Payment System, patients are being discharged in more acute stages of illness. Many patients will need to continue their rehabilitation treatment in outpatient settings. This bill would allow beneficiaries to receive occupational therapy in less costly settings. It will also make the service more accessible, by having it available in rehabilitation agencies and outpatient clinics. If patients do not receive adequate occupational therapy services to help them achieve independent living, it is quite possible that they will be rehospitalized or require greater use of costly institutional services, such as nursing homes.

The Congressional Budget Office (CBO) has established a cost estimate for this legislation of 10–14 million dollars. We believe this is an extremely modest expenditure of Medicare dollars compared to the benefits that would accrue to beneficiaries and the system. Moreover, the CBO estimate does not include any offsetting savings, which we contend would occur immediately if this bill is approved. Let me give you an example—the average cost of one hour of occupational therapy treatment at the outpatient department of a hospital is $63, at an Easter Seal Center in the community—$48, and in an outpatient clinic—$36. We have estimated that if just 10 percent of Medicare beneficiaries received their occupational therapy treatment in a community setting rather than at the outpatient department of a hospital, the Medicare program would save 2.4 million dollars. If 20 percent did so, the savings would be 4.8 million dollars.

Mr. Chairman, let me close with data from 2 studies which show the cost savings when occupational therapy is included in the rehabilitation of patients.

A study of 114 stroke patients received two hours of daily occupational therapy in a rehabilitation program found that the percentage of those able to live at home rose from 37 to 73 percent. The authors of the study found that 21 months after discharge, the cost of the entire program had been offset by the savings of the patients remaining at home.

Another study of 20 multiple sclerosis patients receiving therapy treatment, including occupational therapy, at a rehabilitation center found the patients improved significantly in mobility and self-care activity. As a result, the annual average cost of their care following therapy treatment dropped from 26 thousand dollars to 10 thousand dollars. A savings of 16 thousand dollars per patient!

Mr. Chairman, Medicare coverage of occupational therapy pays off. Extending coverage to these less costly outpatient settings could pay off double or more.

Thank you for the opportunity to present our views. I would be pleased to answer any questions.

The American Occupational Therapy Association, Inc.—Fact Sheet

OCCUPATIONAL THERAPY MEDICARE AMENDMENTS

The Occupational Therapy Medicare Amendments were intorduced in the Senate on March 20, 1985, as S. 723 by Senator Spark Matsunaga with 16 cosponsors. It was introduced in the House on April 4, 1985, by Rep. Lindy Boggs as H.R. 1985 and now has 81 cosponsors.

The Occupational Therapy bill was considered by the 98th Congress as H.R. 2116, with 70 cosponsors, and S. 1615, with 8 cosponsors. H.R. 2116 was approved by the Ways and Means' Health Subcommittee and the full Ways and Means Committee. The committee report (House Report 98–1101) stated, "the value of occupational therapy services to medicare patients, and especially the avoidance or shortening of the need for institutional care that may be possible through the appropriate provision of these services, merits a modest expansion of medicare coverage of occupational therapy services."

THE OCCUPATIONAL THERAPY BILL AND A COMPARISON WITH CURRENT LAW

	Part A	Part B
Proposed amendments		Skilled nursing facility Rehabilitation agencies Private practice
Current Law	Hospital inpatient	Hospital outpatients
	Skilled nursing facility	Physicians' offices
	Home health	Home health
	Hospice	Comprehensive outpatient rehabilitation facility

MEDICARE SAVINGS WOULD RESULT FROM OCCUPATIONAL THERAPY BILL

A study of stroke patients receiving two hours of daily occupational therapy in a rehabilitation program found that the percentage of those able to live at home rose from 37 percent to 73 percent. The authors of the study found that 21 months after discharge, the cost of the entire program had been offset by the savings of the patients remaining at home.

A study of multiple sclerosis patients receiving occupational therapy at a rehabilitation center found that mobility and self care skills had improved significantly. As a result, the annual average cost of their care following therapy treatment dropped from $26,000 to $10,000; a savings of $16,000 per patient.

If just 20 percent of Medicare beneficiaries received their occupational therapy treatment in a community setting (the focus of the occupational therapy bill) rather than the outpatient department of a hospital, the savings would be $4.8 million.

CBO ESTIMATE

The Congressional Budget Office (CBO) has estimated that the occupational therapy proposal would cost the Medicare program an additional $10–14 million. However, this estimate does not take into account any offsetting savings, such as those described above. The CBO is presently investigating the possible savings associated with this bill.

OCCUPATIONAL THERAPY FOR THE MEDICARE PATIENT

rehabilitation service
splinting and specialized treatment to reduce pain and deformity with arthritis
training patients to function independently at home after stroke

perceptual retraining after injury to brain

strengthening and endurance activites for patients with cancer

training in the use of prostheses and adaptive equipment, such as a raised toilet seat

mobility training to prevent decubitus ulcers

teaching swallowing techniques to remove dependency on nasal gastric tube feedings

WHAT IS AN OCCUPATIONAL THERAPIST?

An Occupational Therapist, Registered (OTR) has completed a four-year baccalaureate degree program and six to nine months of supervised fieldwork experience. The occupational therapy curriculum includes courses in developmental psychology, anatomy, neurophyysiology, and the social sciences. The supervised fieldwork covers such areas as psychiatry, physical medicine, gerontology, and developmental disabbilities. There are currently 50 professional level occupational therapy programs in colleges and universities throughout the country. All programs are accredited by the Amerian Medical Association (AMA) in collaboration with The American Occupational Therapy Association, Inc. This collaborative relationship, dating from 1934, is the oldest existing involvement between the AMA and an allied health profession in the accreditation area. At the present time occupational therapists are licensed in 28 states, the District of Columbia, and Puerto Rico.

OCCUPATIONAL THERAPY MEDICARE AMENDMENTS

INTRODUCTION

Occupational therapy is an important component of medical care, and one whose goal is to assist in restoring useful physical function following disabling accident and illness. The occupational therapist works as a member of the rehabilitation team, headed by the physician, along with other health professionals such as physical therapists, speech pathologists and audiologists, social workers and psychologists.

Occupational therapy serves to assist the patient in achieving the maximum level of independent function by mobilizing those capacities which remain after accident, disease, or deformity. Patients include persons suffering from cerebrovascular events (strokes), arthritis, cerebral palsy, spinal cord injuries, hand injuries, amputations and burns, people with visual, auditory and speech disorders, and those with psychiatric problems. Occupational therapy is disected at improving: impaired muscle strength, range of motion, and physical endurance; impaired eye-motor coordination sensory integration and monitor planning; impaired concentration, attention span, thought organization problem solving; and impaired visual-spatial relationships, body schema, figure ground discrimination. The occupational therapist also seeks to prevent muscle atrophy, minimize and prevent deformity, and increase pain tolerance.

LEGISLATIVE BACKGROUND

The Occupational therapy Medicare Amendments (H.R. 1985 and S. 723) would extend Medicare reimbursement under Part B of Title XVIII of the Social Security Act for occupational therapy services in three settings not covered under existing law; (1) skilled nursing facilities; (2) clinics, rehabilitation agencies, and (3) private clinic settings. Currently, occupational therapy is a fully covered service in a hospital, hospice, skilled nursing facility, or home health setting under Part A of Medicare. The present Part B coverage is limited to treatment received in a hospital outpatient department, a comprehensive outpatient rehabilitation facility, a home health agency, or when incident to physician services.

Similar legislation was introduced in the 98th Congress (H.R. 2116 and S. 1615). The House measure was jointly referred to the Committee on Ways and Means and the Committee on Energy and Commerce. The Ways and Means' Health Subcommitee approved the bill unanimously and the full Committee reported the bill favorably on September 28, 1984. However, scheduling constraints precluded the Energy and Commerce Committee from completing action on the bill prior to adjournment of the 98th Congress.

In the 99th Congress the legislation has been introduced in the House by Congresswoman Lindy Boggs (D-LA) with 82 cosponsors, and the companion measure has been introduced in the Senate by Senator Spark Matsunaga (D-HI) was 16 cosponsors.

NEED FOR LEGISLATION

Out-of-hospital treatment has become increasingly important under the Medicare Prospective Payment System. A recent GAO report indicates that patients are being discharged from the hospital sooner and in need of many more services. Without adequate coverage for rehabilitative services, the recidivism rate for patients, particularly the elderly, increases. Recent studies confirm this and substantiate the need for the proposed legislation. One indicates that stroke patients who continue rehabilitation services after they have left a hospital continue to make further progress towards independence. Conversely, a second study indicates that patients whose rehabilitation program is interrupted or is missing a component, such as occupational therapy, do not make further progress and, in fact, lose the independent skills gained during their hospital stay.

The need for occupational therapy coverage under Medicare Part B is particularly urgent in skilled nursing facilities when patients must be switched from Part A to Part B coverage. When this occurs, their rehabilitative process is severed because essential occupational therapy treatment must be discontinued under the provisions of current law.

COST SAVINGS

The treatment in community-based settings proposed in this legislation is a positive, cost-effective refinement of the current program, providing increased access to the services for patients at substantially less cost to the Medicare program. A survey of these services in varied delivery settings confirms these potential savings. For example, just outside Washington, D.C. in the Maryland suburbs, an hour of occupational therapy treatment given at the Montgomery General Hospital is $72.00; at a nearby Easter Seal Center, $40.00; and in a private practice clinic, $35.00. In Miami, Florida, an hour of occupational therapy at Palmetta General Hospital is $144.00; at the Easter Seal Center of greater Miami, $60.00; and in a private clinic, $60.00. If some 40% of Medicare beneficiaries, less than half, were to receive their occupational therapy treatment at one of these less costly and more accessible community settings, $9.6 million in savings would accrue to the program, enough to essentially offset the Congressional Budget Office's estimated first year cost of H.R. 1985 of $9 million. In subsequent years the savings could increase as more beneficiaries begin to utilize the services in these community settings close to them.

These estimated savings do not factor in any additional economies related to the avoidance or shortening of the need for institutional care that may be possible through the timely provision of occupational therapy services. This potential cost-saving aspect of the proposed legislation was of particular interest to the House Ways and Means Committee when it reported similar legislation last year (House Report 98-1101, Part 1).

CONCLUSION

Few legislative proposals have the potential to both refine and improve the delivery and accessibility of health care services and decrease costs. This legislation would achieve these goals in a manner consistent with recent congressional efforts to decrease the long-term costs of health care, while maintaining our commitment to older Americans.

PEMBERTON, NJ,
June 9, 1985.

Hon. H. JAMES SAXTON,
U.S. House of Representatives,
13th Congressional District, New Jersey,
Washington, DC 20515.

DEAR CONGRESSMAN SAXTON: First, I want to thank you for giving me the opportunity to attend the hearing scheduled for June 24 by the Subcommittee on Human Services of the Select Committee on Aging, House of Representatives, in Toms River, Ocean County, NJ. I have enclosed a statement for the Select Committee on Aging, relating, as I perceive, problems facing the aging Veterans of our country. Needless to say, I have not gone into detail, however, I believe my statement, although brief, does reflect my concern on some of the problems facing the aging veteran. I also mentioned the same problems face the aging female veteran as we tend not to think about this group. Again, my thanks to you, and members of your Subcommittee, for allowing me to present a statement for the Committee's reports.

Sincerely,

PAUL J. TULIANO.

PREPARED STATEMENT OF PAUL J. TULIANO, 1985

Mr. Chairman and members of the Subcommittee on Human Services of the Select Committee on Aging, House of Representatives, I want to thank you for taking time to explore the problems of the aging veterans and I deeply appreciate the opportunity you have given me to say a few words on this serious matter.

I will not be redundant—you have heard eloquent testimony given by eminent specialists, concerned and dedicated individuals responsible for providing counseling, and health care services, to the veteran, and aging veteran.

Many aging veterans have experienced pain and frustration in obtaining needed medical care? many older veterans using the VA medical care system have little, or no health insurance.

There is a VA report—"Health insurance coverage among veterans aged 55 years and over," contains data obtained through a survey of aging veterans. Among report findings—"The South had the highest percentage of older veterans with no insurance 13 percent. Almost one-fourth of older veterans with income $10,000 and less, had no insurance, compared with 9 percent of those incomes of $10,000 and $20,000. The VA report stated "among veterans hospitalized in VA medical facilities, only 55 percent have some health insurance, including Medicare and Medicaid).

Mr. Chairman, if I may insert at this point my concern for the aging female veteran. We tend to forget that this group also deserve our attention and their problems, are in many respects, identical to the male veteran.

I'm not aware if any study have been initiated, or completed relating to the aging of the female veteran. If not, perhaps now is the time to highlight this area for specific attention by the VA.

Mr. Chairman, we are aware that the primary function of the VA hospital medical care system is to provide the best possible care for the veterans with service-connected disabilities. However, the intent or our Congress also provides the best care possible for veterans with non-service connected disabilities and this is contained in Public Law 68-242, the World War Veterans Act, Public Law 91-500, amended 39 USC 610 by extending eligibility for VA hospital nursing home and domiciliary care to "any veteran for a non-service connected disability if such veteran is 65 years or older." To reduce funding levels of VA medical care service, or not increasing budget appropriations to keep pace with increased costs, does not bode well for the aging veteran or for the future of the VA medical care system as we know it today. Reduction of funding, results in reduction of personnel levels, including the "hands on providers, mid level supervisory and professional personnel, will definitely reduce quality and timeless of care needed, particularly by the aging veteran and whether service, or nonservice, connected.

Mr. Chairman, to reduce the health medical care eligibility requirements of the non-service-connected veteran, now under consideration by the administration, is indeed a dangerous proposal.

Mr. Chairman, veterans who are using the VA medical care system are either disabled as a result of military service connected disabilities, or, unable to to pay for need and yes, many times urgently needed medical care because of low income and as I stated earlier, with little or no health insurance. After all, these veterans did serve their country honorably and many, although not incurring wounds, or other medical impairments, are considered by the VA to be non-service-connected. they, too, must be considered as part of the aging veteran problem.

Mr. Chairman, I'd like to add, at this point, that the VA must establish a policy, now, for furnishing care to veterans suffering from Alzheimer's disease, this is an insidious disease affecting a large group of our population, including the aging veteran.

Mr. Chairman, I again want to thank you, and members of the Select Committee on the Aging, for the opportunity to appear before the committee and taking your time to permit me to express some thoughts on this important, and yes, serious matter. My sincere thanks to you, Mr. Chairman and members of the Subcommittee on the aging, for directing attention to the problems of the aging veteran. I, and I know many, many veterans are indeed indebted to you for your deep interest and concern on problems affecting them, and are hopeful for solution by a grateful Government.

Thank you.

PAUL J. TULIANO.

OCEAN COUNTY VETERANS SERVICE BUREAU,
Toms River, NJ, June 18, 1985.

Hon. H. JAMES SAXTON,
509 Cannon House Office Building,
Washington, DC.

DEAR SIR: The Ocean County Veterans Service Bureau endorses and fully supports any programs which would enhance the Veterans Administration's medical services to the eligible veterans in Ocean and adjoining Counties.

The need for medical services in this geographic area has been substantiated by the Veterans Administration's briefing report dated March 26, 1985. The Veterans Service Bureau has recognized the need to make available those benefits for which entitlement exists. To alleviate the problems encountered by veterans who have the eligibility for services of the Veterans Administration, but because of the nature of their disabilities, their age, or the distance to the nearest Veterans Administration's medical facility, could not utilize these services, the County of Ocean, through the support and sponsorship of the Board of Chosen Freeholders, has initiated programs which directly addresses the problems. The programs initiated include scheduled transportation to Veterans Administration's medical facilities, and a program which affords professional counseling to Vietnam veterans and to their families. A competent professional service officer has also been added to the staff of the Bureau specifically to meet with and assist the Vietnam veterans in the area. However, these County programs are limited and cannot fully address the veterans administration's responsibilities to the more than 40,000 veterans in the County, and the even larger number of the veterans in the adjoining Counties.

The Veterans Administration has a program for fee basis authorization which, in essence, permits an eligible veteran to obtain medical services from the local, private sector, at Veterans Administration's expense. However, this authorization is very limited and selective, and not readily available to everyone who has Veterans Administration entitlement. The "fee basis" card is authorized or terminated at the determination and whim of Regional Administration. This benefit, at best, is a very fragile benefit, and cannot be construed as an extension of Veterans Administration's medical benefits to satisfy the needs of eligible veterans.

In the past several years the County of Ocean has experienced a rapid rate of population growth. Because of the number of housing developments restricted to persons of mature age, the population growth has reflected large numbers of senior citizens. Proportionately, the veteran population has increased, with significant numbers comprising veterans of World War I and world War II whose medical needs are increased due to age. Concerted effects have also been productive in identifying the Vietnam Veteran and the former prisoner of war, many of whom, by nature of their service, have unique problems and needs.

Recent legislation has addressed specific needs, especially relating to the veterans of World War I, former prisoners of war and Vietnam veterans. Legisltion can acknowledge specific needs and extend eligibility for services, but if these services are not readily and conveniently available, large numbers of veterans are not accorded the benefits which legislation proposes.

When compared with other states with comparable populations, it would appear that New Jersey warrants additional Veterans Administration's medical services to meet the needs of the veterans. It is indisputable that veterans in the Ocean County area must travel unreasonable distances to obtain the Veterans Administration's medical services. For many veterans, because of age or disabilities, medical services from the Veterans Administration are denied because of this distance, even though there is entitlement for such services.

To meet the needs of the veterans, especially the aged or disabled veterans, consideration is requested to approve a Veterans Administration Outpatient Clinic in the geographic area of Ocean County.

Very truly yours,

ROBERT W. ZEHNTNER,
Director.

○